

13293

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 hour</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2202 Dexter Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAY MAXX BELLE Acton</u>				4. DATE OF DEATH Month Day Year <u>December 29 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/20/1885</u>	
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own-home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>George H. Baldwin</u>				14. MOTHER'S MAIDEN NAME <u>Annie Blaine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Sister - Pearl Ferber</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema; Coronary Thrombosis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Myocardial Infarct, left Ventricle.</u> DUE TO (c) <u>Arteriosclerotic Coronary Artery Disease.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 29, 1956</u> , to <u>Dec 29, 1957</u> , that I last saw the deceased alive on <u>Dec 29, 1957</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Edward J. Richards</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Jan 6 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Warner B. Humphrey</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

RECEIVED

13294 CERTIFICATE OF DEATH

13258214
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12816 Parkland Dr.		d. STREET ADDRESS 12816-PARKLAND DR	
3. NAME OF DECEASED (Type or print) ALEX First Middle ALPERT Last		4. DATE OF DEATH DEC. 6 1957 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 5, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY RUSSIA	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB ALPERT		14. MOTHER'S MAIDEN NAME BERTHA GORSTEIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 468-05-5689	
17. INFORMANT SEYMOUR PEPPERMAN Address 12816 PARKLAND DR.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS & INFARCTION 480.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X TUBERCULOSIS ACROSSED			INTERVAL BETWEEN ONSET AND DEATH 24 HRS. 28 YRS.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-30 , 19 54 , to DEC 6 , 19 57 , that I last saw the deceased alive on 12-5 , 19 57 , and that death occurred at 5:30 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1352 UNIVERSITY LANE DATE SIGNED ACTUAL SIGNATURE David Stenberg M.D. HATTISVILLE, MD PHYSICIAN'S NAME (Type) HAROLD SPERLING			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 8, 1957	22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons ADDRESS 3501-1407 NW		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Francis Patten

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13295 CERTIFICATE OF DEATH

Reg. Dist. No. 216

13259

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Nebraska b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 92 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Box #359	
3. NAME OF DECEASED (Type or print) First Neva Middle Faith Last Appleget		4. DATE OF DEATH Month December Day 27 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1909
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing Profession	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Huber		14. MOTHER'S MAIDEN NAME Mary Stroh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 506-24-5493	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and multiple pulmonary abscesses, DUE TO secondary to metastatic carcinoma of the breast. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal decompensation (Uremia - and possible pyelonephritis)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 26, 19 57 , to December 27, 19 57 , that I last saw the deceased alive on December 27, 19 57 , and that death occurred at 12:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/27/57 ACTUAL SIGNATURE Sheldon Kahn M.D. M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) SHELDON KAHN, M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-28-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Home Cem.		22d. LOCATION (City, town, or county) (State) Gage County, Nebraska	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-30-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

Decedent's Name

Age

Sex

Address

City

State

Occupation

Marital Status

Religion

Education

Birth Date

Birth Place

Death Date

Death Time

Death Place

Cause of Death

Immediate Cause

Contributing Cause

Place of Death

Physician's Signature

Physician's Name

Physician's Address

Physician's Signature

Physician's Name

Physician's Address

Physician's Signature

BUREAU V. S.

DEC 31 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13296 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13260

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Remus</u> Middle <u>Awkward</u> Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5/1864</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Presley Awkward</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Addie Hood</u>		Address <u>826 Madison St., D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '57</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 28 1967

BUREAU V. S.

13297 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3513 Edwin St				e. STREET ADDRESS 3513 Edwin St			
3. NAME OF DECEASED (Type or print) First Ella Middle Balcar Last Balcar				4. DATE OF DEATH Month Dec Day 18 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Secretary		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Virginia Thoms				Address Wheaton, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Carcinoma of Rectum DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 mos. + 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from August , 19 57 , to Dec. 18 , 19 57 , that I last saw the deceased alive on Dec. 17 , 19 57 , and that death occurred at 5:08 p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 900 17th St N. W. Washington D. C. DATE SIGNED 12/18/57							
ACTUAL SIGNATURE Thomas E. Curtin M.D.							
PHYSICIAN'S NAME (Type) Thomas E. Curtin				900 17th St N. W. Washington D. C.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DEC 18 1957	
24b. REGISTRAR'S SIGNATURE Alfred							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 04 1957

RECEIVED

13298

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7301 Bradley Blvd.			d. STREET ADDRESS 7301 Bradley Blvd.		
3. NAME OF DECEASED (Type or print) MARY First Louise Middle BARNES Last			4. DATE OF DEATH Dec. Month 18, Day 19 Year 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1870	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse -Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan	
13. FATHER'S NAME Benjamin Balderson			14. MOTHER'S MAIDEN NAME Mary Crisp		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Wm. M. Adgate Address 7301 Bradley Blvd. Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure & Uremia 454.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac decompensation DUE TO (c) 3 mca INTERVAL BETWEEN ONSET AND DEATH 12 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 3/21 , 19 57 , to Dec 18 , 19 57 , that I last saw the deceased alive on Dec 14 , 19 57 , and that death occurred at 7:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2600 Carroll Ave., T. Kansas City DATE SIGNED Raymond O. West ACTUAL SIGNATURE Raymond O. West M D PHYSICIAN'S NAME (Type) Raymond O. West					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
Burial-transit 12-19-57		Chapel Hill Memorial	Lansing, Michigan		
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR DATE 12-20-57	24b. REGISTRAR'S SIGNATURE Theresa M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ELMER A. B.

DEC

CERTIFICATE OF DEATH

Reg. Dist. No.

13263 214

13299

1. PLACE OF DEATH a. COUNTY Montgomery Kensington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington		4. DATE OF DEATH Month Dec Day 25 Year 1957		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium						d. STREET ADDRESS 6307 - 33rd St. N. W.							
3. NAME OF DECEASED (Type or print) First Catherine Middle C Last Barrett		6. DATE OF BIRTH Sept 10, 1885		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. BIRTHPLACE (State or foreign country) Co. Transit Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Asst.				10b. KIND OF BUSINESS OR INDUSTRY Co. Transit				11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Barrett						14. MOTHER'S MAIDEN NAME Catherine Shields							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Sanitarium Records- Kensington, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary sclerosis DUE TO (c) Advanced arteriosclerosis, generalised										INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 5 yrs. 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 1950 to Dec 25 , 1957, that I last saw the deceased alive on Dec 24 , 1957, and that death occurred at 5:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3924 Ingomar St Wash 15 D.C. DATE SIGNED Dec 25 1957													
ACTUAL SIGNATURE Stewart Clapp				M.D. 3924 Ingomar St Wash 15 D.C.				DATE SIGNED Dec 25 1957					
PHYSICIAN'S NAME (Type) Stewart Clapp													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/28/57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Montgomery County, Md.		22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Sheila A. Jones ADDRESS 2901 14th St N.W. Wash 9, D.C.													
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE Frances Fetter									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 1

FUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13260
CERTIFICATE OF DEATH

13264
 713

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>New Jersey</u> b. COUNTY <u>Burlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>	
c. LENGTH OF STAY IN 1b <u>4 wks 6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washburn and Hospital</u>		d. STREET ADDRESS <u>175 W. Pearl St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Marie Elizabeth Beatty</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-88</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Orto C. Hinternech</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Ringmeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>44-18-2118</u>	
17. INFORMANT <u>Chart-Admission record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 11</u> , 19 <u>57</u> , to <u>Dec 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>57</u> , and that death occurred at <u>3:00</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>2600 Carroll Ave</u> DATE SIGNED <u>12-13-57</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		<u>Takoma Park, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cold Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Burlington New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>519-11th St. S. E.</u>		24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Wilson</u>

W. A. DOWNEY

EC

18-1-1914

13261

CERTIFICATE OF DEATH

Reg. Dist. No.

723

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE MD. b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7315 Wildwood Dr.		d. STREET ADDRESS 7315 WILLOWOOD DR	
3. NAME OF DECEASED (Type or print) IRA G. BLUMER		4. DATE OF DEATH Dec 28 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-83
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXCAVATOR OPERATOR		11. BIRTHPLACE (State or foreign country) WASH. DC	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick Blumer	
14. MOTHER'S MAIDEN NAME Elizabeth Baker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT VIRGINIA L BLUMER Address 7315 Wildwood Dr	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Superior mechanical obstruction 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of uterine DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-7 , 1957 , to 12-28 , 1957 , that I last saw the deceased alive on 12-27 , 1957 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel M. Baggett M.D. 5600 N.H. Ave Wash DC		DATE SIGNED 12/28/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-31-57	
22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Neal Leonard Home ADDRESS 4812 Ga Ave NW		24a. REC'D BY REGISTRAR C 30157	
		24b. REGISTRAR'S SIGNATURE Wilson Duddy	

BUREAU V. 2

DEC 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13300

CERTIFICATE OF DEATH

13266

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
c. LENGTH OF STAY IN 1b 5 YRS.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,903 JUDSON ROAD				d. STREET ADDRESS 11,903 JUDSON ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ETHYL Middle V. Last BOLLAN				4. DATE OF DEATH Month 12 Day 20 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 1, 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR				10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue		11. BIRTHPLACE (State or foreign country) ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME BENJAMIN LEACH				14. MOTHER'S MAIDEN NAME NORA CARPENTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO NONE		17. INFORMANT Mr. Robert G. Bollan, 11,903 Judson Road Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Coronary Arterio-sclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 12/31/57			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 3, 1957 to Dec 18, 1957 , that I last saw the deceased alive on Dec 18, 1957 , and that death occurred at 7:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1835 EYE ST N.W. D.C. DATE SIGNED William S. Miller							
ACTUAL SIGNATURE William S. Miller M.D.							
PHYSICIAN'S NAME (Type) William S. Miller, M.D. 1835 EYE ST N.W. D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 12/23/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey ADDRESS Silver Spring, Md.				24a. REC'D BY REGISTRAR DEC 23 1957		24b. REGISTRAR'S SIGNATURE Frances Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 1957

RECEIVED

13301 CERTIFICATE OF DEATH

13267

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1011 Rockcrest Dr.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Leroy Bollinger</u>				4. DATE OF DEATH Month Day Year <u>Dec. 18 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>William C. Bollinger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Murtland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hazel Bollinger</u> Address <u>1011 Rockcrest Dr. Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pylephlebitis</u>						1 day	
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) <u>Ascending Cholangitis</u> 3 days	
DUE TO							
(c) <u>Biliary Obstruction, Common Duct, due to stone</u>						10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8-3</u> , 19 <u>55</u> to <u>Dec 18</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Dec 17</u> , 19 <u>57</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.							
PHYSICIAN'S NAME (Type) <u>George Sharpe, M.D.</u>				1			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Bur-Transit</u>		<u>12/19/57</u>		<u>Mt. Pleasant, Pennsylvania</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

23 23 23

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13262

13268
Reg. Dist. No. 423

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

BUREAU V. S.

DEC 30 1957

RECEIVED

13302

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Olney</u> , <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>2101 2nd. St. N. E.</u> b. COUNTY <u>#1 Washington, DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dawn Adrienne Boston</u>				4. DATE OF DEATH Month Day Year <u>December 29 19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/57</u>	9. AGE (In years last birthday) yrs. <u>8</u> Months <u>93</u> Days <u>93</u> Hours <u>93</u> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Charles C. Boston</u>				14. MOTHER'S MAIDEN NAME <u>Helen B. Bacon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Helen Boston (mother)</u> <u>2101 2nd. St. N. E. Washington, D. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>500X</u> DUE TO <u>schizophrenia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diarrhea</u> (c) <u>Acute Tracheobronchitis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4/1</u> , 19 <u>57</u> , to <u>12/29</u> , 19 <u>57</u> that I last saw the deceased alive on <u>12/29</u> , 19 <u>57</u> , and that death occurred at <u>11:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>C. H. Ligon</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>1/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope</u>		22d. LOCATION (City, town, or county) <u>Colesville, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sward</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1/6 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Yulanda Taylor</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 A 0-50

1 A 0-50

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
6M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13270

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12813 Georgia Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 12813 Georgia Ave.	
3. NAME OF DECEASED (Type or print) Charles First Botts Middle Last		4. DATE OF DEATH Dec. 13, 1967 Month Day Year	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1887
9. AGE (In years, months, days) 70 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeffery Botts		14. MOTHER'S MAIDEN NAME Margaret Sedgwick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Arthur Botts		Address Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/67	
22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant		22d. LOCATION (City, town, or county) (State) Norbeck, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DEC 20 1967 DATE	
		24b. REGISTRAR'S SIGNATURE James Potter	

MEDICAL CERTIFICATION

2

BUREAU V. E.

DEC 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13304 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10707 Bentley Lane</u>				d. STREET ADDRESS <u>10707 Bentley Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Ragnhild Holst Brandrup</u>				4. DATE OF DEATH <u>Dec 21</u> 1957			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-1-1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARL HOLST Christensen</u>				14. MOTHER'S MAIDEN NAME <u>Nielsine MARIE Peterson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-34-6093</u>		17. INFORMANT <u>Victor Brandrup (son) same as Ilin</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio-renal disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Grand mal 30 yrs</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13305

CERTIFICATE OF DEATH

13272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>612 University Blvd West</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTO P BRANDY</u>				4. DATE OF DEATH Month Day Year <u>December 18 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-28-1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE OWNER RETIRED DELICATESSEN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GREECE</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Petro Brandy</u>				14. MOTHER'S MAIDEN NAME <u>Theodora Vlaho</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-14 7790</u>		17. INFORMANT <u>Shera Brandy</u> Address <u>2730-52nd Ave S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac some decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 1/2 yrs</u> <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. (City or town) <u>---</u>				20g. (County) <u>---</u>		20h. (State) <u>---</u>	
21. I certify that I attended the deceased from <u>Feb. 18</u> , 19 <u>55</u> , to <u>Dec. 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 16</u> , 19 <u>57</u> , and that death occurred at <u>12:55 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1629 Columbia Rd., N.W., Wash 9, D.C.</u> DATE SIGNED <u>12/18/57</u>							
ACTUAL SIGNATURE <u>George Dewey</u> M.D.				PHYSICIAN'S NAME (Type) <u>George Dewey</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers C</u>				ADDRESS <u>1400 Chapin St</u>		24a. REC'D BY REGISTRAR <u>---</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURMAN V. E.



Itmes 1, 2, 3, 4, 1-7-5, 6

Reg. Dist. No.

13273 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westmoreland Hills</u>		c. LENGTH OF STAY IN 1b <u>Westmoreland Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At his home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>M.</u> Last <u>Britton</u>		4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel H. Lee</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Trodden</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Mrs Rose Steinbuckl</u>		17. INFORMANT <u>5214 Farnington Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs.</u> <u>10 yrs</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1951, to <u>Dec 27</u> , 1957, that I last saw the deceased alive on <u>Dec 27</u> , 1957, and that death occurred at <u>11:35</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore J. Abernethy</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1834 Eye St. N.W. Washington D.C.</u>	
PHYSICIAN'S NAME (Type) <u>THEODORE J. ABERNETHY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-31-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 4th St & Mass Ave</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
24b. REGISTRAR'S SIGNATURE <u>Thomas P. Peters</u>			

RECEIVED

JUL 30 1957

BUREAU V. T.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13263 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13274

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sand & Hosp		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> 17 Takoma Park	
f. NAME OF DECEASED (Type or print) Anna Catherine Brown First Middle Last		d. STREET ADDRESS 7000 Westmoreland Ave	
3. NAME OF DECEASED (Type or print) Anna Catherine Brown First Middle Last		4. DATE OF DEATH Month 12 Day 6 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-91
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Braun		14. MOTHER'S MAIDEN NAME Weirthner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Washington San & Hosp Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1st add 2nd degree burns involving about 85% of body and extremities DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crown caught afire when coal oil was poured in furnace		
20c. TIME OF INJURY Month, Day, Year 4:45 p. m. 11-30, 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Takoma Pk		(County) Montg Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 10, 1957
22c. NAME OF CEMETERY OR REMATORY Port Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Geo. Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walter</i>		24. REC'D BY REGISTRAR 12/9/57
ADDRESS 254 Carroll St NW DC.		24b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. A.

CO. 1.

1-1-1

1-1-1

13307 CERTIFICATE OF DEATH

13275 214
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Wisconsin</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>6 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baraboo, Wisconsin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8208 Nolte Avenue</u>				d STREET ADDRESS <u>4217 Mulberry St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Lora</u> First <u>May</u> Middle <u>Brown</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/78</u>	9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert B. Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Adora J. Griswold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Mrs. Josephine Mason, 8208 Nolte Ave. Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4400</u> IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cerebrovascular Disease</u> DUE TO <u>Vascular Disease</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 26</u> 19 <u>57</u> , to <u>Dec 1</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 30</u> 19 <u>57</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 University Blvd E. Silver Spring, Md.</u> DATE SIGNED <u>12/1/57</u>							
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u>				M.D. <u>217 University Blvd E. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL 12/2/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>WALNUT HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BARABOO, WISCONSIN</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances T. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NO 4 1957

BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13308

CERTIFICATE OF DEATH

13276

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 23 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS 9620 BEXHILL DR.			
3. NAME OF DECEASED (Type or print) First THOMAS Middle EDGAR Last BRUST				4. DATE OF DEATH Month Dec Day 15 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 1, 1877	
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		11. BIRTHPLACE (State or foreign country) FREDERICK MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES BRUST				14. MOTHER'S MAIDEN NAME ANNIE STULL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RODGER BRUST Address 621 Shandon St Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) CORONARY THROMBOSIS							INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 DAY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic atherosclerosis, aorta, right femoral artery							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-14 , 1957, to 12-15 , 1957, that I last saw the deceased alive on 12-15 , 1957, and that death occurred at 7:55 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Kiernan				ADDRESS (Street, city or town, state) DATE SIGNED WASHINGTON CLINIC 12-16-57			
PHYSICIAN'S NAME (Type) PAUL KIERNAN							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		12-18-57		MT. OLIVET		FREDERICK MD.	
23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME				ADDRESS 4812 Ga. Ave NW		24a. REC'D BY REGISTRAR DEC 20 1957	
						24b. REGISTRAR'S SIGNATURE Ressie Thompson	

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13277

Reg. Dist. No. 216

13309

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryl nd</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>R.F.D. 1, River Road</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gwynne</u> Middle <u>Michelle</u> Last <u>Bryan</u> 4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 4, 1940</u> 9. AGE (In years last birthday) <u>17</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Lubbock, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Weyland E. Newton</u>				14. MOTHER'S MAIDEN NAME <u>Nelba Louise Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>525-82-9269</u>		17. INFORMANT Address <u>6101 Dunbar Court Bethesda, Maryland</u> <u>Mrs. Nelba Kline</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia & atelectasis (bilateral)</u> 4 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral contusion & Multiple Cerebral Hemorrhages</u> 5 days DUE TO (c) <u>auto accident</u> 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rupture of stomach</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car which ran into rear of truck</u>					
20c. TIME OF INJURY Month, Day, Year <u>12/3/57</u> Hour <u>2:30</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Prosser</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Prosser</u>				DATE SIGNED <u>12/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) <u>Arlington, Virginia.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>12/11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

RECEIVED

13310 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New Rochelle	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4961 Allen Road, Westmoreland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 81 Forest Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Fannie M. BULL		4. DATE OF DEATH Month Day Year December 23 19 57		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1866		9. AGE (In years last birthday) 91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New York City	
13. FATHER'S NAME George G. Moore		14. MOTHER'S MAIDEN NAME Harriett Whitlock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address George G. Bull-4961 Allen Rd. Wash. 16, D. C.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) myocardial infarction DUE TO 3 mo 3+ yr					INTERVAL BETWEEN ONSET AND DEATH 3 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5522 Western Ave	
20f. (City or town) Prince Georges		20g. (County) Maryland		20h. (State) Md.	
21. I certify that I attended the deceased from 19 Nov 57 to 23 Dec 57 , that I last saw the deceased alive on 22 Dec 57 , and that death occurred at 3:55 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE A. H. Richwine		M.D. 5522 Western Ave		DATE SIGNED 23 Dec 1957	
PHYSICIAN'S NAME (Type) A. H. RICHWINE		Cherry Chase Rd 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/23/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) Prince Georges		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-24-57		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, and 2 should be filled with post-mortem should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 27 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13311 CERTIFICATE OF DEATH

Reg. Dist. No.

13274/216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 days</u>		d. STREET ADDRESS <u>801 Dryden Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Theresa</u> Last <u>BULMER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 28, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Ireland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Daniel Hoey</u>	
14. MOTHER'S MAIDEN NAME <u>Rose Ann Keenan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-32-2381</u>		17. INFORMANT <u>Rosemary Armstrong</u> Address <u>1225 Sutherland Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Portal Cirrhosis</u> DUE TO <u>JAHO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19 </u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 18</u> , 19 <u>57</u> , to <u>DEC 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. W. E. DeLaater M.D.</u>		ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD Bethesda Md</u>	
PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLaater M.D.</u>		DATE SIGNED <u>12/4/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Edgewood</u>	24b. REGISTRAR'S SIGNATURE <u>REC'D BY REGISTRAR DEC 12 1957</u>

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RECEIVED

13312

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 mos. 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
f. STREET ADDRESS 9338 Columbia Blvd.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Quilty Last CLARK				4. DATE OF DEATH Month December Day 11 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Sept. 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Michael QUILTY				14. MOTHER'S MAIDEN NAME Mary CLARY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. None		17. INFORMANT Son-In-Law, John M. FINLEY (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extension of Right Cerebral Vascular Occlusion 15 mins. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Thrombotic Phenomena 2 months DUE TO (c) arterosclerotic Heart Disease & Atrial Fibrillation Years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralytic ileus. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 16 Sept. , 19 57 , to 11 Dec. , 19 57 , that I last saw the deceased alive on 10 Dec. , 19 57 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-12-57							
ACTUAL SIGNATURE F.S. Caldwell				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) F.S. CALDWELL, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-57		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Springfield, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey, 8434 Georgia Ave. Silver Spring, Md.				24a. REC'D BY REGISTRAR DATE 12-11-57		24b. REGISTRAR'S SIGNATURE Mary E. Parvilly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

1957

RECEIVED

13313

CERTIFICATE OF DEATH

13281

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles C. Clark</u>				4. DATE OF DEATH Month Day Year <u>12 27 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/75</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Ret.) Asst. Chief Weather Bureau</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ezra W. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Ann Nadine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or not known) <u>NE</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT (Name and Address) <u>Son (Duncan) 24 S. Perry St. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>							<u>6 hrs.</u>
450.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Congestive Heart Failure</u>							<u>2 weeks</u>
(c) <u>Advanced General Arteriosclerosis</u>							<u>10 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>Diabetes Mellitus - mild</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>April 12, 1957</u> to <u>Dec. 27, 1957</u> , that I last saw the deceased alive on <u>Dec. 26, 1957</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Y. Jagers, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>Frank Y. Jagers, Jr., M.D.</u>				DATE SIGNED <u>12/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Dist. Columbia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>12-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Horn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC

1911

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13314 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13282

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 1 1/2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 229 WHITMOOR TERRACE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 229 WHITMOOR TERRACE e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAULINE First Middle Last CLOUD		4. DATE OF DEATH Month Day Year DEC. 28 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/85
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WIEDEMANN		14. MOTHER'S MAIDEN NAME PAULINE ROTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Pauline C. Padden		Address 229 Whitmoor Terrace Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) 423.1 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Found dead in bed DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCHART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/28/57	
22a. BURIAL CREMATION REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/30/57	22c. NAME OF CEMETERY OR CREMATORY GREEN HILL CEMETERY	22d. LOCATION (City, town, or county) (State) WAYNESBORO, PENNSYLVANIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 2 1958	24b. REGISTRAR'S SIGNATURE James H. Hottel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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QUARTER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13315

CERTIFICATE OF DEATH

13283

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Rest Home				d. STREET ADDRESS 502 Dahlia St., N.W.			
3. NAME OF DECEASED (Type or print) First LOUISE Middle Bartlett Last COAKE				4. DATE OF DEATH Month DEC. Day 16 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/82	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months 3 Days 24 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. K. Bartlett				14. MOTHER'S MAIDEN NAME Juliet Reese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs R.A. Humphrey Address 7902 Kentbury Dr., Beth.Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE HEART DISEASE DUE TO (c) ESSENTIAL HYPERTENSION						INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (GIVEN IN PART I) (a) GENERALIZED ARTERIO-SCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 30, 1952 to DEC. 16, 1957 , that I last saw the deceased alive on DEC. 16, 1957 , and that death occurred at 1:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2206 ACRWAY DR BALTIMORE, MD DATE SIGNED 12/16/57							
ACTUAL SIGNATURE Henry H. Louder M.D.				PHYSICIAN'S NAME (Type) HENRY H. LOUDER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/57		22c. NAME OF CEMETERY OR CREMATORY Friends Burial Ground		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 12-18-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 A may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 2 1964

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13264

CERTIFICATE OF DEATH

13284

Reg. Dist. No. 773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmingdale, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>447 South Hampton Dr. N.W. Hpts</u>			
3. NAME OF DECEASED (Type or print) First <u>Zona</u> Middle <u>Kate</u> Last <u>Conner</u>				4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-84</u>	
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswn.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Cavett</u>				14. MOTHER'S MAIDEN NAME <u>Sally Tucker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Chart</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>Dec 2</u> , 19 <u>57</u> , to <u>December 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 6</u> , 19 <u>57</u> , and that death occurred at <u>2:35</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1019 University Boulevard Silver Spring, Md.</u> DATE SIGNED <u>12/6/57</u>							
ACTUAL SIGNATURE <u>Boris Rabkin</u>				PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) <u>PRINCE GEORGE COUNTY, MD.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arnell E. Humphrey</u> ADDRESS <u>8434 Laidlaw</u>				24a. REC'D BY REGISTRAR <u>DEC 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPT. OF JUSTICE

RECEIVED
JAN 10 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film G223 12-27-57 et
CERTIFICATE OF DEATH

13285

Reg. Dist. No. 215

13316

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE TENNESSEE b. COUNTY UNKNOWN			
b. CITY OR TOWN (If outside corporate limits, write nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 12 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, BETHESDA, MARYLAND				d. STREET ADDRESS LAKE RD.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JERE Middle (N) Last COOPER				4. DATE OF DEATH Month December Day 18 Year 1957			
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1893		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Politics		10b. KIND OF BUSINESS OR INDUSTRY U.S. Congressman		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOE WILLIAM COOPER				14. MOTHER'S MAIDEN NAME VIOLA MAE HILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) UNKNOWN (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT OFFICIAL U.S. NAVY DOCUMENTS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0						13 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Arteriosclerotic Heart Disease DUE TO 20 unknown	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-5 , 19 57 , to 12-18 , 19 57 that I last saw the deceased alive on 12-18 , 19 57 , and that death occurred at 6:29 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thirl E. Jarrett M.D.				ADDRESS (Street, city or town, state) USNH, BETHESDA, MARYLAND			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Thirl E. JARRETT		USNH, BETHESDA, MARYLAND					
22a. BURIAL OR CREMATION (Specify) 12/24/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Dyersburg Tennessee	
23. FUNERAL DIRECTOR'S SIGNATURE JOSEPH CAWLEERS SONS ADDRESS 1756 PENN. AVE N.W. WASH D.C.				24a. REC'D BY REGISTRAR 12/18/57		24b. REGISTRAR'S SIGNATURE Mary E. P. P. P.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1944

DEC

13317
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3508 Leland Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
f. STREET ADDRESS 3508 Leland Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Burton Last Corning		4. DATE OF DEATH Month Dec. Day 7 Year 1957	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1889
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months 3 Days 23	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Albert Edward Corning		14. MOTHER'S MAIDEN NAME Annie Laurie Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-34-8995	
17. INFORMANT Margaret W. Corning		Address same as 2 d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum cell Sarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cause unknown DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year 19 Hour a. m. p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1947 , to Dec 7 , 19 57 , that I last saw the deceased alive on Dec 7 , 19 57 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St. NW. Wash 15 D.C. DATE SIGNED Dec 7 1957			
ACTUAL SIGNATURE Stewart Crapp		M.D. 3921 Ingomar St. NW. Wash 15 D.C.	
PHYSICIAN'S NAME (Type) Stewart Crapp		Wash 15 D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/11/57	22c. NAME OF CEMETERY OR CREMATORY Slatville Presy. Ch.	22d. LOCATION (City, town, or county) (State) Whiteford, Penn Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 12-11-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13287

Reg. Dist. No. 216

13318

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town) Bethesda			c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Urban hosp.				d. STREET ADDRESS 138 E. Middle Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Richard Middle Covington Last				4. DATE OF DEATH Month 12 Day 17 Year 57				
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/19/18		
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rockingham, No. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Covington				14. MOTHER'S MAIDEN NAME Bessie Dunlap				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Hosp Record - Dora Covington (1st cousin,				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (b) Peripheral venous thrombosis (c), stating the underlying cause last, DUE TO Fractures of tibia and fibula, bilateral							INTERVAL BETWEEN ONSET AND DEATH minutes days 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atelectasis due to aspirated gastric contents								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) struck by auto while standing behind his car for repair					
20c. TIME OF INJURY Month, Day, Year Hour 4:45 p.m. 12/5/57 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) Silver Spring Montg. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/18/57				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-20-57		22c. NAME OF CEMETERY OR CREMATORY Holly Grove Cem.		22d. LOCATION (City, town, or county) Rockingham N.C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry L. Washington & Sons</i>				24a. REC'D BY REGISTRAR DEC 28 1957		24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BOULEVARD Y. S.

EC. 1937

VED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
\$M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13319 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13288

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5301 Wilson Lane		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bethesda d. STREET ADDRESS 5301 Wilson Lane e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katherine Louise Craig First Middle Last 4. DATE OF DEATH Dec. 5, 1957 19 Month Day Year		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 6/30/1911 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) 48 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY D.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Horace H. Smith		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Donald A. Craig		Address Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 420.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/5/1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/6/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 12-6-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

U. S. A.

1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13320 CERTIFICATE OF DEATH

13289

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park	
		d. STREET ADDRESS 4401 Oxford Street,	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Gertrude Last CUNNARE		4. DATE OF DEATH Month December Day 1 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 August 1885
		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Massachusetts
		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William DUFFY		14. MOTHER'S MAIDEN NAME Johanna DALY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO 032-20-8318	
		17. INFORMANT Son, Francis H. Cunnare (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE CEREBRAL EMBOLI DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYELOID METAPLASIA DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 3 YEARS +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIOVASCULAR DISEASE, ADVANCED		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 Nov. , 19 57 , to 1 Dec. , 19 57 , that I last saw the deceased alive on 1 Dec. , 19 57 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-2-57			
ACTUAL SIGNATURE Frederick S. Caldwell M.D.			
PHYSICIAN'S NAME (Type) Frederick S. Caldwell, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-6-57	22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	22d. LOCATION (City, town, or county) (State) Waltham, Massachusetts
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-2-57	
		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

RECEIVED

DEC 4 1957

BUREAU V. S.

Reg. Dist. No. 13290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jeannette</u> Middle <u>(None)</u> Last <u>Cunningham</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-82</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswn.</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
13. BIRTHPLACE (State or foreign country) <u>Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Thomas Jackson</u>		16. MOTHER'S MAIDEN NAME <u>Jeannette Stevenson</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>none</u>	
19. INFORMANT <u>Chart</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that <u>this admission</u> attended the deceased from <u>12-21-</u> , 19 <u>57</u> , to <u>12-25-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-25-</u> , 19 <u>57</u> , and that death occurred at <u>1:40 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7894 Georgia Ave., Silver Spring, Md.</u> DATE SIGNED <u>12-25-57</u> ACTUAL SIGNATURE <u>READ N. CALVERT, M.D.</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>12/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL GARDENS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FAIRMONT, WEST VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Kinsley Inc.</u>		ADDRESS <u>Silver Spring, Md.</u> REC'D BY REGISTRAR <u> </u> DATE <u>12/27/1957</u>	
24a. REGISTRAR'S SIGNATURE <u>J. H. Woodbridge</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. E.

DEC 27 1967

RECEIVED

Cause of death—MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Anoxia

13321

CERTIFICATE OF DEATH

Reg. Dist. No.

13321

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>37 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>15908 Beech Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Shamus Jr. Middle</u>				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28, 1957</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Leslie A. Daly Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Babette Sonya Trojstad</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give year or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Leslie A. Daly</u> Address <u>5908 Beech Ave Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u>
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anoxia</u>							
DUE TO <u>Euphrasius Fictatus</u>							unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ph. hemolysis</u>							
DUE TO <u>Ph. hemolysis</u>							
(c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>28 Dec 1957</u> to <u>28 Dec 1957</u> , that I last saw the deceased alive on <u>28 Dec 1957</u> , and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda 14 Md</u>				DATE SIGNED <u>28 Dec 1957</u>			
ACTUAL SIGNATURE <u>Michael L Buckley</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Michael L Buckley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>12-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

2074293XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES

DEC 21 1964

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13322

CERTIFICATE OF DEATH

13292

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D. of C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				d. STREET ADDRESS <u>1121 New Hampshire Avenue, N. J.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A.</u> Last <u>Daly</u>				4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1957</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1900</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>57</u> Days <u>24</u> Hours <u>1957</u>	IF UNDER 24 HRS Months <u>57</u> Days <u>24</u> Hours <u>1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Daly</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Virginia McNamee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W. War I</u>				16. SOCIAL SECURITY NO. <u>Hospital record</u>		17. INFORMANT <u>Mr. Leslie Daly</u> Address <u>4402 East-West Hwy Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema, severe</u> DUE TO (b) <u>Multiple focal cerebral infarctions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastritis, hypertrophic and hemorrhagic</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 9, 1957</u> to <u>Dec 24, 1957</u> , that I last saw the deceased alive on <u>Dec 23, 1957</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joyce</u>				DATE SIGNED <u>12/24/57</u>			
PHYSICIAN'S NAME (Type) <u>Joyce</u>				ADDRESS (Street, city or town, state) <u>Bethesda, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>12-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Harrison</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1957

RECEIVED

13266 CERTIFICATE OF DEATH

13293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Haven Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle A. Last Davies		4. DATE OF DEATH Month Dec Day 20 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1874
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 24 Days 10 Hours 00 Min.	11. IF UNDER 24 HRS. Months 00 Days 00 Hours 00 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Service Agent - Express		10b. KIND OF BUSINESS OR INDUSTRY Fruit Growers	
11. BIRTHPLACE (State or foreign country) Erie, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Davies		14. MOTHER'S MAIDEN NAME Esther George	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Ruth D. Gossert		Address 212 Manor Circle Takoma Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 2, 1955 to 20 Dec, 1957 , that I last saw the deceased alive on 19 Dec, 1957 , and that death occurred at 3:42 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M B Queen		DATE SIGNED 20 Dec 1957	
PHYSICIAN'S NAME (Type) M B. QUEEN		ADDRESS (Street, city or town, state) 7112 Willow Ave Takoma Park, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St., N.W. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE John W. Brady		DATE DEC 24 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AD V. S.

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 show the certificate forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18, 20, 21

13323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13294

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 205 Timberwood Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Northwood High School		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Timothy James Davis		4. DATE OF DEATH Dec. 19, 1957	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/23/1942	
9. AGE (in years last birthday) 15 yrs		10. IF UNDER 1 YEAR Months Days Hours M. n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY N.Y.	
11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James Davis		14. MOTHER'S MAIDEN NAME Nadine Moon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Jas. Davis, Same as Item 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to Cardian contusion DUE TO 106.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral contusion & concussion DUE TO (c) Accidental			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Collapsed while playing basket ball			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> High School	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) High School		20f. (City or town) (County) (State) Mont	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/20/57	
22a. BURIAL CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/23/57	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey Inc		ADDRESS 55 S. 4th St Baltimore	
24a. RECEIVED BY REGISTRAR Frances Tally		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

2 1957

RECEIVED

13324

CERTIFICATE OF DEATH

13295216

Reg. Dist. No

Item 21 Film G223 12/13/57 GE

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 320 Livingston Terrace, S.E.	
3. NAME OF DECEASED (Type or print) First Catherine Middle Lee Last Delk		4. DATE OF DEATH Month December Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 21, 1957
9. AGE (In years last birthday) yrs. 9 Months 23 Days 9 Hours 23 Min		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Delk		14. MOTHER'S MAIDEN NAME Peggy Joyce Cregar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Wilm's tumor of the right kidney with chest metastases. (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 8, 19 57 , to December 9, 19 57 , that I last saw the deceased alive on December 9, 19 57 , and that death occurred at 11:55 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/15/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE Richard Shaw M.D.			
PHYSICIAN'S NAME (Type) RICHARD SHAW, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12-15-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. M. Chambers		ADDRESS Washington, D. C.	
24a. REC'D BY REGISTRAR DEC 1		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Broschart, Medical Examiner, was notified of this death and instructed on the matter. He will approve certificate and did not want to come in.

200VVVVVXVV

EDWARD A. S.

1870

1870

13325

CERTIFICATE OF DEATH

13299
Reg. Dist. No. 276

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wisconsin b. COUNTY Rock	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3704 Leland St.		d. STREET ADDRESS 718 Washington St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LUCY Middle ESGAR Last DICKINSON		4. DATE OF DEATH Month Dec Day 1 Year 1957	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1867
9. AGE (In years and birthday) 90 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Charles W. Esgar		14 MOTHER'S MAIDEN NAME Ellen Abbott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT Daughter Mrs. Wm. H. Bonneville		Address Item #1	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 years (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February, 1946 to January, 1957 , that I last saw the deceased alive on Oct 30 , 19 57 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1714-N-St. N.W. Washington D.C. DATE SIGNED			
ACTUAL SIGNATURE J. Lawn Thompson, Jr.		M.D. 1714-N-St. N.W. Washington D.C.	
PHYSICIAN'S NAME (Type) J. LAWN THOMPSON, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial-transit	12-3-57	Albion Prairie Cem.	Dane County, Wisconsin
23 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 12-8-57		24b. REGISTRAR'S SIGNATURE Bessie S. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN V. B.

2011

RECEIVED
JAN 10 2011

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13297

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				e. STREET ADDRESS <u>4602 Chelton Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Carter</u> Last <u>Dooley</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>1.</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1936</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Computer Oper.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Research Lab.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Benjamin Clarence Dooley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Louise Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-34-4478</u>		17. INFORMANT <u>Mrs. Margaret Louise Carter Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & Laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound in rt. Skull</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted</u>			
20c. TIME OF INJURY Month, Day, Year <u>12/1/57</u> Hour a. m. <u>12:45</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
20f. (City or town) <u>Kensington</u>				(County) <u>Montg.</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	
22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u>				(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>12-2-57</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>		DATE SIGNED <u>12/1/57</u>	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. AIR FORCE

1947

- MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
13327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13298
 Reg. Dist. No. **216**

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Dickerson			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 1 None			
3. NAME OF DECEASED (Type or print) First John Middle Harvey Last Dove				4. DATE OF DEATH Month Dec. Day 25 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1877		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Criders, Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Ruben Dove			14. MOTHER'S MAIDEN NAME Amelia ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Arnold B. Dove		Address R. 6 Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-pneumonia (bilateral) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9. c. fracture of left hip 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at home					
20c. TIME OF INJURY Month, Day, Year 12/23/1957 Hour 6:30 o. m. P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Dickerson (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Bonhart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) rank J. Br os eners				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 12/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28 1957		22c. NAME OF CEMETERY OR CREMATORY Beallsville		22d. LOCATION (City, town, or county) Beallsville (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				24a. REC'D BY REGISTRAR DATE 12-30-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY
WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13328 Item 12-4-57-23-12-4-57-b
 CERTIFICATE OF DEATH

13299

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPIELANE Nursing Home Inc.</u>		d. STREET ADDRESS <u>1523 22nd St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>KATE</u> Last <u>DURANT</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1874</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Clerk</u>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <u>83</u> yrs.
10a. BIRTHPLACE (State or foreign country) <u>Bishopville, S.C.</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. FATHER'S NAME <u>ANDREW CLAYENCE DURANT</u>		12. MOTHER'S MAIDEN NAME <u>Camella C. Dixon</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NAVY 9-6-1918-7-31-19</u>		14. SOCIAL SECURITY NO. <u>5-6-1918-7-31-19</u>	
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>		16. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SCENILITY</u>			
17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
18a. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		18b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		18d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 2</u> , 19 <u>55</u> , to <u>12-4-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-4-</u> , 19 <u>57</u> , and that death occurred at <u>7:10</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>3206 Norway Dr. Chevy Chase, Md.</u> DATE SIGNED <u>12/4/57</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ant. Nat. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington - Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Wash D.C.</u> ADDRESS <u>300-4th St. N.E.</u>		24. REC'D BY REGISTRAR <u>DEC 9</u> DATE <u>DEC 9</u>	
		25. REGISTRAR'S SIGNATURE <u>Frances Patton</u>	

EDWARD A. B.

1957

RECEIVED

BUREAU V. S.

DEC 27 1957

RECEIVED

13330 CERTIFICATE OF DEATH

13301

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 7		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6415 Wilson Lane		1 d. STREET ADDRESS 6415 Wilson Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) J. WARD EICHER		4. DATE OF DEATH Month Dec. Day 5 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 10 Days 28	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gov't Employee	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME John Eicher	
14. MOTHER'S MAIDEN NAME Weaver		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. 578-36-7548		17. INFORMANT Wife Georgia M. Eicher Address 6415 Wilson La. Bethesda, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic left ventricular failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 44 Dec 5 51	20f. (City or town) Bethesda (County) (State)
21. I certify that I attended the deceased from July 51 19 54 to Dec 5 51 19 51 , that I last saw the deceased alive on Dec 5 51 19 51 , and that death occurred at 9:38 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Chevy Chase Drive Chevy Chase, Maryland DATE SIGNED Dec 5 51			
ACTUAL SIGNATURE George A. Gray, Jr.		M. D. 	
PHYSICIAN'S NAME (Type) George A. Gray, Jr.		Chevy Chase, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE WHEREOF 12/7/57	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 12-6-57		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be kept with the body prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

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RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13331 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13302

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gravel pit - Green Castle Rd</u>		d. STREET ADDRESS <u>Box 67 - miles Rd</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE First FRANK Middle lost</u>		4. DATE OF DEATH <u>Dec 22 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-10</u>
9. AGE (In years last birthday) <u>47 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Life Ins. Co. Insurance Agent</u>	
11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE WASHINGTON ELEY</u>		14. MOTHER'S MAIDEN NAME <u>unknown Courtney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>yes</u>	
17. INFORMANT <u>Mrs. Beulah Miles Eley, Miles Road, R.F.D.#2 Laurel, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cirrhosis</u>			
973.1 DUE TO (b) <u>Cancer in mesencephalon</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in auto with attachment inserted in muffle into body of car</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BURTNSVILLE UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner L. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24. REC'D BY REGISTRAR <u>12-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>Francis C. Catter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1917

RECEIVED

CERTIFICATE OF DEATH

13303 773
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. DC.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SAN. & HOSPITAL</u>				d. STREET ADDRESS <u>1412 OAK ST. NW, WASH DC.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN GWENDOLYN TAEBER</u>				4. DATE OF DEATH Month Day Year <u>DEC. 30 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1903</u>	9. AGE (In years last birthday) <u>54 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. GALT BURNS</u>				14. MOTHER'S MAIDEN NAME <u>HELEN DUNN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-20-0102</u>		17. INFORMANT Address <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Renal Disease</u> DUE TO (c) <u>Hypogenesis Left Kidney -</u> 30 years from birth							INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cystic degeneration Right Pancreas, Brain due to thrombosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter not applicable if not applicable) <u>Myocardial infarction</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-16-1954</u> to <u>12-30-1957</u> , that I last saw the deceased alive on <u>12-30-1957</u> , and that death occurred at <u>5:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. Shoemaker</u>				ADDRESS (Street, city or town, state) <u>8005 Woodbury Dr. Silver Spring, Md.</u>			
DATE SIGNED <u>12/30/57</u>							
PHYSICIAN'S NAME (Type) <u>M.C. SHOEMAKER, MD-</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan Inc</u>				ADDRESS <u>317 Penn.</u>		24a. REC'D BY REGISTRAR <u>JAN 2</u>	
				24b. REGISTRAR'S SIGNATURE <u>William A. Addy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1950

RECEIVED

13304

Reg. Dist. No.

214

13332

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>414 Belton Road</u>				e. STREET ADDRESS <u>1 414 Belton Road</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Dominic</u> Last <u>Fitzgerald</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 17 1916</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber, Inspector D. C. Gov't.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmund Fitzgerald</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Fegahn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>Yes</u> <u>World War I</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edmund Fitzgerald</u> Address <u>6633 1st St N Arlington, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>4 wks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>U93X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug. 12 1957</u> to <u>Dec 16 1957</u> , that I last saw the deceased alive on <u>Dec 16 1957</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city, or town, state), DATE SIGNED <u>Raymond Bradshaw</u> M.D. <u>345 University Blvd., West</u> <u>Dec 16, 1957</u> PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u> <u>Silver Spring, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1957

REC

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13305

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN lb 20 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			d. STREET ADDRESS 11709 Grandview Avenue
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roland Middle Wayne Last Frasher		4. DATE OF DEATH Month December Day 25 Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1916	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Belmont County, Ohio		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Mr. Martin Luther Frasher			14. MOTHER'S MAIDEN NAME Miss Della Campbell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1945 220-12-3165		17. INFORMANT Address Wife, Mrs. Alice Frasher		same as dec	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. Broschart			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			12-26-57	
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-28-57		Parklawn		Rockville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm E. Humphrey				ADDRESS Silver Spring		24b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR	
				DATE DEC 27 1957			

TO FURNISH DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.
 TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

BUREAU OF

NOV 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1338614

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 show the certificate forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9609 Delston Rd</u>		d. STREET ADDRESS <u>9609 Delston Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Harber</u> Middle Last		4. DATE OF DEATH <u>Dec 1</u> 19 <u>57</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-15</u> 9. AGE (In years last birthday) <u>42</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Harber</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Barr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>YES</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>577-26-3373</u>	
17. INFORMANT <u>Betty Galstein</u>		Address <u>12058 Milton St Wheaton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> cause last, (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom</u>		22d. LOCATION (City, town, or county) (State) <u>Cop Hts. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. DC</u>		24a. REC'D BY REGISTRAR <u>12/6/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

U.S. A.

REC

RECEIVED

13334 CERTIFICATE OF DEATH

13303/6
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 36 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 2912 Sycamore Street	
3. NAME OF DECEASED (Type or print) First Leo Middle Clair Last Garcin		4. DATE OF DEATH Month December Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1924
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Writer		10b. KIND OF BUSINESS OR INDUSTRY Publications	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Pierre J. Garcin		14. MOTHER'S MAIDEN NAME Lydia Bellan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 370-18-4597	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subacute bacterial endocarditis DUE TO (c) Rheumatic valvulitis (aortic insufficiency)			INTERVAL BETWEEN ONSET AND DEATH 3 months 6 mo. years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple pulmonary infections			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 29, 1957 , to December 4, 1957 , that I last saw the deceased alive on December 4, 1957 , and that death occurred at 7:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12/5/57 The National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE James L. German, M.D.		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) James L. German, M.D.		M.D. The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Interment	22b. DATE THEREOF 12-9-57	22c. NAME OF CEMETERY OR CREMATORY Art. Hall	22d. LOCATION (City, town, or county) (State) Arlington 15
23. FUNERAL DIRECTOR'S SIGNATURE W. H. ...		ADDRESS Alexandria	
24a. REGD BY REGISTRAR 12-9-57		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirley</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u> d. STREET ADDRESS <u>2018 Shoufeld Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Giovanna</u> Middle <u>—</u> Last <u>Giannola</u>		4. DATE OF DEATH Dec 28 1957	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4 1880</u> 77 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>—</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Jasper Giannola</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident (Stroke)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 1953</u> to <u>28 Dec 1957</u> , that I last saw the deceased alive on <u>28 Dec 1957</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris Perry</u>		M.D. <u>11602 Georgia Ave.</u> <u>12-28-57</u>	
PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		<u>Silver Spring Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W R Thornton & Son</u>		24a. REC'D BY REGISTRAR <u>NEW</u>	24b. REGISTRAR'S SIGNATURE <u>Francis J. Kelly</u>

BUREAU V. I.

DEC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13336

CERTIFICATE OF DEATH

Reg. Dist. No.

13302/4

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakview		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1307 Dilston Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GENEVA Middle E Last GILES		4. DATE OF DEATH Month Dec. Day 26, Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1890
9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Portsmouth, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Everling		14. MOTHER'S MAIDEN NAME Louise Shearer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Nathan B. Giles-1307 Dilston Road,		Address Oakview, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) 421.4 DUE TO acute cardiac dilatation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocarditis (c) valvular heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypothyroidism with obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15, 1947 to Dec 26, 1957 that I last saw the deceased alive on Dec 26, 1957 and that death occurred at 3:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Ryon, M.D.		ADDRESS (Street, city or town, state) 401 W. 1st St.	
PHYSICIAN'S NAME (Type) William A. Ryon, M.D.		DATE SIGNED 12/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/30/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR DEC 30 1957	24b. REGISTRAR'S SIGNATURE Frances Tolley

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NO 1957

BUREAU V. B

13290 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tipton Rest Home</u>		d. STREET ADDRESS <u>i</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Edith</u> Last <u>Gloyd</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home work</u>	
11. BIRTHPLACE (State or foreign country) <u>Germantown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James Edward Wallich</u>		14. MOTHER'S MAIDEN NAME <u>Annie Bennett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Carlton A. Gloyd. Gaithersburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>Dec 26</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>57</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. A. Linthicum</u> M.D.		ADDRESS (Street, city or town, state) <u>26 N. Summit Ave. Gaithersburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wm. A. Linthicum</u>		DATE SIGNED <u>Dec. 27, 1957.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Rose,</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR <u>James Kragh</u> DATE <u>Jan 8</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

13269 CERTIFICATE OF DEATH

Reg. Dist. No.

13311

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 mo. 5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>12</u> - Day <u>8</u> - Year <u>1957</u>				5. STREET ADDRESS <u>419 Boyd Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>BERNARD</u> Middle <u>PRESTON</u> Last <u>Godbold</u>				6. DATE OF BIRTH <u>10-21-88</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Conditioning</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Godbold</u>				14. MOTHER'S MAIDEN NAME <u>Alice Redcliffe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Chart + wife</u> Address <u>419 Boyd Ave. Takoma Park</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock - Internal Hemorrhage</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) <u>Parkinson's Disease - Cerebral Deterioration</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 3/4 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 25</u> , 19 <u>55</u> , to <u>Dec 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>57</u> , and that death occurred at <u>8:00</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Ireby</u>				ADDRESS (Street, city or town, state) <u>7105 Riggs Rd. Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Ireby</u>				DATE SIGNED <u>Dec 8, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/11/57</u>		<u>St. Lincoln Cemetery</u>		<u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. H. H. H.</u>				24a. REC'D BY REGISTRAR <u>W. S. H. H. H.</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. H. H. H.</u>	
				DATE <u>11 1957</u>			

U.S. AIR FORCE

1954

1954

13337 CERTIFICATE OF DEATH

Reg. Dist. No. 21 13312

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Maryland		d. STREET ADDRESS 818 S. Florida St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gerald Middle Allen Last GOLEMAN		4. DATE OF DEATH Month December Day 3 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-57
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Bobby Lane GOLEMAN		14. MOTHER'S MAIDEN NAME Elita June Brock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT (Father) Bobby Lane Goleman (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central Nervous System anoxia DUE TO (c) Pulmonary Hyaline Membrane Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Dec. 19 57 , to 3 December 19 57 , that I last saw the deceased alive on 3 December 19 57 , and that death occurred at 9:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Adam G. Thorp, Jr.		M.D. U.S. Naval Hospital, Bethesda Md. 12-4-57	
PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md. 12-4-57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-9-57	Arlington Natl Cemetery	Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. REC'D BY REGISTRAR 12-4-57	
ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Mary E. Connelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1331314

Reg. Dist. No. 212

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12007 Milton St.</u>		e. STREET ADDRESS <u>6006 41st. Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Ethel Wood Gott</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/1880</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Dr. Robert Wood</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Worthington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Jos. Burriss, Same as Item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/4/57</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	22d. LOCATION (City, town, or county) (State) <u>Beallsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u>		24a. REC'D BY REGISTRAR <u>Barndsville Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>James C. Hilton</u>		DATE <u>12/7/57</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

WAVE

13270 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

133143
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN lb <u>27 hrs.</u>		d. STREET ADDRESS <u>501 Tulip Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Jane</u> Last <u>Gottwals</u>		4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey Rosenberger</u>		14. MOTHER'S MAIDEN NAME <u>Martha Zirkle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>WASH DC</u>	
17. INFORMANT <u>Niece - Mrs. B. Her.</u>		Address <u>421 Peabody St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration and contusion of brain, due to</u> <u>812x</u> DUE TO (b) <u>fracture of the skull.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rupture of diaphragm with herniation of the stomach into the left pleural cavity.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Struck by auto while crossing street</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-18</u> Hour <u>11-30</u> a.m. <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Takoma Park, Montg</u> (County) <u>MD</u> (State) <u>MD</u>	
27. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Brischant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BRISCHANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 4, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN REFORMATION CHURCH CEMETERY</u>		22d. LOCATION (City, town, or county) <u>NEW MARKET VA.</u> (State) <u>VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Brischant</u>		24a. REC'D BY REGISTRAR <u>DEC 3 - 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Frank J. Brischant</u>		24c. REGISTRAR'S SIGNATURE <u>Frank J. Brischant</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

DEC 4 1957

BUREAU V. 3

CERTIFICATE OF DEATH

13339

13315
Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. COUNTY Montgomery MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville—Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matthews Nursing Home		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Elizabeth First Neer Middle Grubb Last		4. DATE OF DEATH Month Dec Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18-1875
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Grubb		14. MOTHER'S MAIDEN NAME Marguretta Neer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edgar Grubb, Beallsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm Abdom. Aorta DUE TO Hypertensive-Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive-Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 M. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1954, to 2 Dec , 1957, that I last saw the deceased alive on 29 November , 1957, and that death occurred at 11012A , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Bearsville, Md	
PHYSICIAN'S NAME (Type) Gordon M. Smith		DATE SIGNED 20 Dec 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/57	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton		ADDRESS Bearsville, Md	
24a. REC'D BY REGISTRAR DATE 12/4/57		24b. REGISTRAR'S SIGNATURE Charles W. Elgin	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

150-654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 12-20-57 et

CERTIFICATE OF DEATH

13340

13316

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY D.O.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADAMSCVS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY COUNTY GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>-</u>			
3. NAME OF DECEASED (Type or print) First <u>KATTIE</u> Middle <u>N</u> Last <u>HACKETT</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 23, 1908</u>	
9. AGE (In years last birthday) <u>49</u> yrs		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>		IF UNDER 24 HRS Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES EDW. JONES</u>				14. MOTHER'S MAIDEN NAME <u>HARRIETT FARR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Vada Mullinix, Adams, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO <u>IX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Hypertension and Cardiac Hypertrophy</u> (c) <u>Bronchial Asthma and Arrested T.B. of lungs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>5 or more years</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic nephritis, Bacterial endocarditis (1953)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>57</u> , to <u>Dec 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>57</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. F. Meadors</u>				ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M.D.</u>				DATE SIGNED <u>12/11/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/14/57</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Wash. Nat'l.</u>		22d. LOCATION (City, town, or county) (State) <u>PR. Geo. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>				ADDRESS <u>3012 - M St. NW. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 16 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			

BUREAU V. S.

DEC 10 1961

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cause of death—MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Coronary Thrombosis 13291 CERTIFICATE OF DEATH

13317

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b XXXXX d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5810 Wicomico Ave.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 5810 Wicomico Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY FRANCES HARMON First Middle Last			4. DATE OF DEATH Dec. 27, 1957 Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1888	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR: Months 0 Days 20 Hours 19 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John William Hoffman			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME Elizabeth Phelps			17. INFORMANT Lester M. Harman-Norbeck, Md. Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ESSENTIAL ARTERIAL HYPERTENSION TEN YEARS DUE TO (c) CORONARY ARTERY DISEASE FIFTEEN YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from DEC 23, 1957 to DEC 27, 1957 , that I last saw the deceased alive on DEC 27, 1957 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Gordon S. Rosenberger M.D.			ADDRESS (Street, city or town, state) 2601 SUMMIT BLVD, MD. DATE SIGNED Dec 27, 1957		
PHYSICIAN'S NAME (Type) Gordon Rosenberger					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn	
22d. LOCATION (City, town, or county) (State) Rockville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.			24a. REC'D BY REGISTRAR DATE 12-30-57		
			24b. REGISTRAR'S SIGNATURE Bessie M. Thompson		

EDWARD V. S.

DEC

1-6-44

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13341

CERTIFICATE OF DEATH

Reg. Dist. No. 133486

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>2808 Weisman Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>David MacNeil Harrison</u>				4. DATE OF DEATH Month Day Year <u>December 13 19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1908</u>	9. AGE (In years lost birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>wholesale TV</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Arthur Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Ada - Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>016-10-0303</u>		17. INFORMANT Address <u>Mrs. Deloris Harrison 2808 Weisman Rd. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-13-57</u> 19 <u>57</u> , to <u>12-13-57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12-13-57</u> , 19 <u>57</u> , and that death occurred at <u>AP</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12/13/57</u>							
ACTUAL SIGNATURE <u>Morris Perry</u> M.D.				12/13/57			
PHYSICIAN'S NAME (Type) <u>Morris Perry, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BULLY V. 1

10 19 1957

10 19 1957

13342

Iter 6 File 24 1-3-57 et
CERTIFICATE OF DEATH

13319

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Boyd's, Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Catherine</u> Last <u>Hawkins</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15-1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>		11. BIRTHPLACE (State or foreign country) <u>Boyd's Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Jones</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mr. Lawrence Hawkins</u>		Address <u>Boyd's, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>at heart</u> (c) <u>2 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4. Pneumonia left lower lobe</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 19, 1957</u> , to <u>Dec 22, 1957</u> , that I last saw the deceased alive on <u>Dec 21, 1957</u> , and that death occurred at <u>5:35 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D.				ADDRESS (Street, city or town, state) <u>8337 Georgia Ave Silver Spring, Md</u>			
DATE SIGNED <u>12-23-57</u>							
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Jackson</u>				ADDRESS <u>Clarksburg</u>		24a. REC'D BY REGISTRAR <u>Bessie M. Thompson</u>	
DATE <u>12-24-57</u>				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 27 1966

BUREAU Y. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
13344 CERTIFICATE OF DEATH											
Reg. Dist. No. 13321											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN Hospital</u>					d. STREET ADDRESS <u>4611 Wilwynn Way</u>						
3. NAME OF DECEASED (Type or print) First <u>BARB</u> Middle <u>BOY</u> Last <u>HERON</u>					4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>8</u> Year <u>1957</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 8</u>		9. AGE (In years last birthday) yrs <u>1</u> Months <u>30</u> Days <u>30</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Edward Heron</u>					14. MOTHER'S MAIDEN NAME <u>Eileen McKane</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT Address <u>Father - 4611 Wilwynn Way Rockville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> DUE TO <u>777</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MISCARRIAGE 5 1/2 mo</u> DUE TO <u>—</u> (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 HR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8016 Georgetown Rd Bethesda Md</u> DATE SIGNED <u>12/8/57</u>											
ACTUAL SIGNATURE <u>LE I OORUVAN MD</u> M.D.					PHYSICIAN'S NAME (Type) <u>Bethesda Md</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR <u>12-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beanie M. Pumphrey</u>				

2074222XVO

RECEIVED

APR 11 1964

13343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

211

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Boyd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Ground Rd</u>		d. STREET ADDRESS <u>White Ground Rd</u>	
3. NAME OF DECEASED (Type or print) <u>John Raymond Hebron</u>		4. DATE OF DEATH <u>12-10-1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-92</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HR Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U-S-C</u>	
13. FATHER'S NAME <u>John W. Hebron</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Doyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Ruth E. Hebron - Boyd</u>		Address <u>md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Smoke & fumes</u> DUE TO (c) <u>fire of bed at home</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1st & 2nd degree burns of face & arms</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Bed caught afire while asleep</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> p.m. <u>12-9</u> 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>home</u>	20f. (City or town) <u>Boyd</u> (County) <u>Montg</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>12-10-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shouder</u>		24a. REC'D BY REGISTRAR <u>DEC 13 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Hella W. Burdette</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 'A OVER

RECEIVED

13345

CERTIFICATE OF DEATH

13322

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8807 Glenville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>X</u> Last <u>Hershowitz</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-93</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sheet Metal Wkr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Hershowitz</u>		14. MOTHER'S MAIDEN NAME <u>Annie - (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>? years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10-5-</u> , 19 <u>53</u> , to <u>Dec 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>57</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Cassell Ave Takoma Park Md</u> DATE SIGNED <u>12/20/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, Md.</u>		<u>Coronary notified nurse approved</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/22-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Hebrew Cong.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash D.C.</u>		ADDRESS <u>24a. REC'D BY REGISTRAR</u> <u>24b. REGISTRAR'S SIGNATURE</u> <u>James Catter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1870

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1332314

13346

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>N Jersey</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>				c. LENGTH OF STAY IN 1b <u>4 months</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jersey City</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>				e. STREET ADDRESS <u>358 Armstrong Ave</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle Last <u>HEYMAN</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WH</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>UNKNOWN</u>	
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET CONTRACTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>SIDNEY HEYMAN</u> Address <u>7416 GLENSIDE DR. TAKOMA PARK, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic kidneys</u> DUE TO <u>Generalized arteriosclerosis</u> (c) <u>Cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>other</u> <u>15 2 years</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>57</u> , to <u>Dec 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>57</u> , and that death occurred at <u>2:30 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Caron H. Trau</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave - Silver Spring Md</u> DATE SIGNED <u>12/22/57</u>			
PRINTED NAME (Type) <u>Caron H. Trau</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GUTERMAN FUNL HOME</u>		22d. LOCATION (City, town, or county) (State) <u>Jersey City, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Guterman Funeral Home</u> ADDRESS <u>4217-9th Ave</u>				24a. REC'D BY REGISTRAR <u>DEC 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Pitter</u>	

BUREAU A. E.

1957

RECEIVED

13347 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia c. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #3, Box 514			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Deborah Kathryn Holland				4. DATE OF DEATH Month Day Year December 3, 1957			
5. SEX Female		6. COLOR OR RACE Negroid		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 7, 1951	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James Mercer				14. MOTHER'S MAIDEN NAME Ruby K. Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest at operation 704.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease - Truncus Arteriosus DUE TO (c) 6 yrs INTERVAL BETWEEN ONSET AND DEATH Immediate							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 24, 1957 , to December 3, 1957 , that I last saw the deceased alive on December 3, 1957 , and that death occurred at 12:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12-3-57 The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Clarence S. Weldon M.D.				PHYSICIAN'S NAME (Type) Clarence S. Weldon, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-7-57		Shiloh Bapt.		Adams Corner Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Chini ADDRESS Washington, Va.				24a. REC'D BY REGISTRAR DATE 12-11-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 4 1972

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13348

CERTIFICATE OF DEATH

Reg. Dist. No.

13325
2/7

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brinklow</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Montgomery General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>William</u> Last <u>HOLLAND</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 9, 1916</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u>		IF UNDER 24 HRS Hours <u>19</u> Min <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>garden</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>HARRY HOLLAND</u>				14. MOTHER'S MAIDEN NAME <u>MADDER MATHEWS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>W.W.I. #2</u>				16. SOCIAL SECURITY NO. <u>217-14-7188</u>			
17. INFORMANT <u>Self</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> <u>70</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Illness</u> DUE TO (c) <u>Acute Pancreatitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>57</u> , to <u>12/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/18</u> , 19 <u>57</u> , and that death occurred at <u>5:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. LIGOR</u>				M.D. <u>James J. Ligon</u>			
PHYSICIAN'S NAME (Type) <u>C. H. LIGOR</u>				DATE SIGNED <u>12/18/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Ligon</u>				ADDRESS <u>Rockville, Md.</u>		24. REGISTRAR'S SIGNATURE <u>Gertrude Loring</u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 27 1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13349 CERTIFICATE OF DEATH

13326 17

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md 4 yrs 8 mos</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 4 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Beau Gardens Sant.</u>				d. STREET ADDRESS <u>1213-33rd St NW</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A.</u> Last <u>HOUSER</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 25, 1871</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>		11. BIRTHPLACE (State or foreign country) <u>POTOMAC, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEVI HOUSER</u>				14. MOTHER'S MAIDEN NAME <u>MARY COLLINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-01-9995</u>		17. INFORMANT Address <u>Francis Houser, 1213-33rd St NW Wash, DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Debilitation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Chronic Heart Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 19, 55</u> to <u>Dec 1, 1957</u> that I last saw the deceased alive on <u>Nov 30, 1957</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u>				PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau</u> <u>10609 Concord St, Kensington Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>POTOMAC CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>POTOMAC MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>3072-M St NW Wash, DC</u>				24a. REC'D BY REGISTRAR <u>DATE 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>	

RECEIVED
DEC 4 1957
BUREAU Y. S.

Reg. Dist. No.

13350

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

NAVY V. S.

DEC 1 1957

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13328

Reg. Dist. No. 217

13351

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood R - 1</u>		c. LENGTH OF STAY IN 1b <u>Derwood R - 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Muncaster Mill Rd.</u>		d. STREET ADDRESS <u>Muncaster Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Earl Jarrett</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/1903</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur W. Jarrett</u>		14. MOTHER'S MAIDEN NAME <u>Vannie Jattis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>578427982</u> 17. INFORMANT <u>Police record</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/15/57</u>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 17, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Meth.</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u>		24a. REC'D BY REGISTRAR <u>12-19-57</u> 24b. REGISTRAR'S SIGNATURE <u>Arvinde B. Lawley</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1/20/1917

1917 - 1917

1917 - 1917

21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13271

CERTIFICATE OF DEATH

133243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 81 Willow Ave.	
3. NAME OF DECEASED First William Middle Otis Last Jennings		4. DATE OF DEATH Month Dec. Day 22 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/14
9. AGE (In years last birthday) 43		10. IF UNDER 1 YEAR Months 22 Days 15 Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? West Virginia	
13. FATHER'S NAME Otis Vernon Jennings		14. MOTHER'S MAIDEN NAME Nora Belle Dressler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 191-12-1234	
17. INFORMANT Hospital Records		Address Keyser, West Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia DUE TO (c) Chronic Glomerulonephritis		INTERVAL BETWEEN ONSET AND DEATH One day Three months One year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month — Day 19 Hour — a. m. — p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Dec 12, 1957 to Dec 22, 1957 , that I last saw the deceased alive on Dec 22, 1957 , and that death occurred at 5:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Morton Eanet		ADDRESS (Street, city or town, state) 900 17th St. N.W. Wash.	
PHYSICIAN'S NAME (Type) MORTON EANET M.D.		DATE SIGNED J.C. 12/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY Keyser, West Virginia	22d. LOCATION (City, town, or county) (State) Keyser, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 14th St. N.W. Washington, D.C.	
24b. REGISTRAR'S SIGNATURE —		DATE —	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 11 1944

BUREAU A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 10, 11, 12, 13-15, et

13330

CERTIFICATE OF DEATH

Reg. Dist. No. 215

13352

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN TB 4 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Markham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS Gibraltar Farm		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Hall Last JESCHKE		4. DATE OF DEATH Month December Day 15 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894 22 December 1894	9. AGE (In years last birthday) 62 62 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Harry Jewett JESCHKE		14. MOTHER'S MAIDEN NAME Nellie JEWETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Margaret Devereux Jeschke	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS & HYPERTENSION DUE TO (c) 12 years.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 11 Dec. , 19 57 , to 15 Dec. , 19 57 , that I last saw the deceased alive on 15 Dec. , 19 57 , and that death occurred at 8:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-16-57					
ACTUAL SIGNATURE F.S. Caldwell		PHYSICIAN'S NAME (Type) F.S. CALDWELL, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Chambers Funeral Home, 3072 M St. N.W.		24a. REC'D BY REGISTRAR DATE 12-16-57		24b. REGISTRAR'S SIGNATURE Amey B. Russell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 19 1907

RECEIVED
DEC 19 1907

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13353 CERTIFICATE OF DEATH

13331 4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13613 SHERWOOD FOREST DR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ASTRID SOPHIE JOHNSON</u>		4. DATE OF DEATH Month Day Year <u>DEC. 15 19 57</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 28, 1881</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MICH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN B. JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>T. ROBERT JOHNSON</u>		Address <u>6715 RELEE RD FALLS CHURCH VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January, 1956</u> , to <u>Dec. 15, 1957</u> , that I last saw the deceased alive on <u>Dec. 15, 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Robert Perkins</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1463 - Rhode Island Ave NW 12/16/57</u>	
PHYSICIAN'S NAME (Type) <u>William Robert Perkins M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Less Son</u>		ADDRESS <u>Wash. D. C.</u> 24a. REC'D BY REGISTRAR <u>DATE 18 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Pattery</u>	

U. S. A.

DEC

13272

CERTIFICATE OF DEATH

Reg. Dist. No.

13332 3

1. PLACE OF DEATH p. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Rivers George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				d. STREET ADDRESS <u>5906 Sheridan St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harold Plant Johnson</u>				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-99</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Engrs.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John C. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Settle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>7LE</u>		16. SOCIAL SECURITY NO. <u>578-034272</u>		17. INFORMANT <u>Chert</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemo peritoneum</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture arteriosclerotic aortic aneurysm</u> DUE TO (c) <u>Coronary Occlusions</u>							INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>? hours</u> <u>2 1/2 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-1-</u> , 19 <u>57</u> , to <u>12-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-24</u> , 19 <u>57</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Lakewood Park, Md.</u> DATE SIGNED <u>12/25/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. HARE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASH. NAT. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>NW Chambers Co.</u>				ADDRESS <u>5801 Cleveland Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Nelson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 7 01

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

13333

13292

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery Co.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> LENGTH OF STAY (In this place) <u>1 yr.</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15209 Rosecroft Rd.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> TOWN STREET ADDRESS (If rural, give location) <u>15209 ROSECROFT ROAD</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>KARL</u> (Middle) <u>JUDICKE</u> (Last)				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>5</u> (Year) <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Aug 22/1913</u>	
9. AGE last birthday <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Production Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Rheinhold Judicke</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kramer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>136-14-3259</u>		17. INFORMANT <u>Widow</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>Carcinoma of lung</u> Antecedent cause(s) (b) <u>Arteriosclerosis - right bundle branch block</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>March 23/1957</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis - right bundle branch block</u>							
19a. DATE OF OPERATION <u>March 23/1957</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of lung - inoperable</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office hldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 15, 1957</u> , to <u>Dec 5, 1957</u> , that I last saw the deceased alive on <u>Nov 23, 1957</u> , and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Leslie W Harris M.D.</u>				ADDRESS <u>10111 Callesville Rd Silver Spring Md</u>		DATE SIGNED <u>12-5-57</u>	
23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>12/9/57</u>		NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
DATE REC'D BY LOCAL REG. <u>12-17-57</u>		REGISTRAR'S SIGNATURE <u>Charles L. Little</u>		24. FUNERAL DIRECTOR <u>Warner B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Two for One: FilmG223 12-30-57 et



BUREAU V. S.

DEC 31 1957

RECORDED

13354 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 43 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5708 Danny's Lane			
3. NAME OF DECEASED (Type or print) First Wilhelmina Middle Suarez Last KETTERER				4. DATE OF DEATH Month December Day 23 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 July 1881	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Ralldolph SUAREZ				14. MOTHER'S MAIDEN NAME Mary Mildred JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO Unknown		17. INFORMANT Address (Son) Frederick KETTERER (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Pulmonary Embolism, Left upper lobe DUE TO 4 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO 4 weeks (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8 November 19 57 , to 23 December 19 57 , that I last saw the deceased alive on 23 December 19 57 , and that death occurred at 8:37 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-23-57							
ACTUAL SIGNATURE John Craighead M.D.							
PHYSICIAN'S NAME (Type) John Craighead, LCDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-57		22c. NAME OF CEMETERY OR CREMATORY Barrancas Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Pensacola, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home ADDRESS 2847 Wilson Blvd. Arlington, Va.				24a. REC'D BY REGISTRAR DATE 12-23-57		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 30 1957

BUREAU V. F.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

133355

133355

214

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PAN PAW	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAN PAW	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS ROUTE #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) OLLIE'S SNACK BAR		e. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GILBERT CLARENCE KIDWELL		4. DATE OF DEATH Month Day Year DECEMBER 5, 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 19, 1897
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator of cranes & tractors		10b. KIND OF BUSINESS OR INDUSTRY Ray Construction Co	
11. BIRTHPLACE (State or foreign country) Paw Paw, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Kidwell		14. MOTHER'S MAIDEN NAME Cordelia Kidwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 236-50-1573	
17. INFORMANT Mrs. Olive Kidwell, 3601 Weller Rd. S. S. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 430.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 12/5/57	
EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery		22d. LOCATION (City, town, or county) (State) Paw Paw, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS 8434 Georgia Ave. Silver Spring, Md.		24a. REC'D BY REGISTRAR DEC 9 1957	
24b. REGISTRAR'S SIGNATURE Francis P. Patter			

RECEIVED

RECEIVED

13356

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Washington, D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 51 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, BETHESDA, MARYLAND				d. STREET ADDRESS 3409 O St., N.W., WDC			
3. NAME OF DECEASED (Type or print) First Middle Last TRACY BARRETT KITTREDGE				4. DATE OF DEATH Month Day Year December 22 19 57			
5. SEX MALE		6. COLOR OR RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 May 1891	
9. AGE (In years last birthday) 66 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. NAVAL RESERVE				10b. KIND OF BUSINESS OR INDUSTRY USN		11. BIRTHPLACE (State or foreign country) OREGON	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME HERBERT KITTREDGE				14. MOTHER'S MAIDEN NAME JESSE GROOVES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO UNKNOWN		17. INFORMANT OFFICIAL NAVY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hodkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 November 1957 to 22 December 1957 , that I last saw the deceased alive on 22 December 1957 , and that death occurred at 7:14 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USNH, BETHESDA, MARYLAND 12-22-57							
ACTUAL SIGNATURE August Miale Jr.				M.D. USNH, BETHESDA, MARYLAND			
PHYSICIAN'S NAME (Type) A. MIALE Jr.				USNH, BETHESDA, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-22-57		22c. NAME OF CEMETERY OR CREMATORY ANCIENT CEMETERY		22d. LOCATION (City, town, or county) (State) WISCASSETT MAINE	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY				ADDRESS 757 Wisconsin Ave., Bethesda, MD		24a. REC'D BY REGISTRAR DATE 12-22-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

DEC 20 1937

RECEIVED

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

13357

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Chevy Chase		c. LENGTH OF STAY IN b 3520 Bradley Lane		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Chevy Chase		d. STREET ADDRESS 3520 Bradley Lane		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORA		First		Middle C.		Last KNAPP		4. DATE OF DEATH Dec. 19 19 57		Month		Day		Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/27/70		9. AGE (In years and birthday) 87 yrs.		IF UNDER 1 YEAR Months 3 Days 29		IF UNDER 24 HRS. Hours 3 Min. 29			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) W. Virginia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Mathew V. Callaway								14. MOTHER'S MAIDEN NAME Alice Callahan							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Montg. Co. Police				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 hrs															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				EXAMINER'S NAME (Type) Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/20/57			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/23/57				22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company								24a. REC'D BY REGISTRAR 2901 14th St., N.W.				24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNNY V. S.

REC 28 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13338
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 214
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.					
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MANCHESTER 9051 Manchester Rd.					STREET ADDRESS 9051 MANCHESTER ROAD 9051 Manchester Rd.					
3. NAME OF DECEASED (Type or print) Augustus Washington Knox, Jr.					4. DATE OF DEATH Dec. 23, 1957					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/1903		9. AGE (in years last birthday) 54 yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor			10b. KIND OF BUSINESS OR INDUSTRY Tel. Co.		11. BIRTHPLACE (State or foreign country) N.C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Augustus Washington Knox Sr.					14. MOTHER'S MAIDEN NAME Eliza Smides					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			16. SOCIAL SECURITY NO. 061-10-4193		17. INFORMANT Eliza Smides Knox Sameas Address Item 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Barbiturate poisoning Found dead in bed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found dead in bed (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)				
TRANS & BURIAL		12/24/57		Oakwood Cemetery		Raleigh, North Carolina				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Humphrey					ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE James Pattery	

DEC 26 1957

BUREAU V. S.

DEC 10 1957

RECEIVED

13273 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hospital</u>				d. STREET ADDRESS <u>3806 Flower Ave.,</u>			
3. NAME OF DECEASED (Type or print) <u>Infant Girl</u> First Middle Last				4. DATE OF DEATH <u>December 14, 1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 12, 1957</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u>		IF UNDER 24 HRS Days <u>2</u> Hours <u>44</u> Min. <u>44</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Ralph Stanley Leacy</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ann Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mother's chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory + Cardiac Failure.</u>							
DUE TO (b) <u>Prematurity.</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12 Dec., 1957</u> to <u>14 Dec., 1957</u> , that I last saw the deceased alive on <u>14 Dec., 1957</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Bier</u> M.D.				ADDRESS (Street, city or town, state) <u>9028 Woodland Drive Silver Spring Maryland.</u> DATE SIGNED <u>12/16/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Bier</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Bier</u> ADDRESS <u>Washington San. & Hospital</u>				24a. REC'D BY REGISTRAR <u>DEC 21 1957</u> 24b. REGISTRAR'S SIGNATURE <u>J. H. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
F. B. I.

DEC

1964

13274

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
c. LENGTH OF STAY IN 1b 19 hours 39 min				d. STREET ADDRESS 3806 Flower Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Infant Boy Leacy				4. DATE OF DEATH Month December Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1957	9. AGE (In years last birthday) yrs 19	IF UNDER 1 YEAR Months 19 Days 39	IF UNDER 24 HRS Hours 19 Min. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ralph Stanley Leacy				14. MOTHER'S MAIDEN NAME Barbara Ann Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother's chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory & Cardiac Failure 74X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 12, 1957 to Dec. 13, 1957 , that I last saw the deceased alive on Dec. 13, 1957 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Bier				ADDRESS (Street, city or town, state) 9028 Woodland Dr. 16 Dec. 57			
PHYSICIAN'S NAME (Type) Robert A. BIER				DATE SIGNED Silver Spring Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-18-57		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hosp. Takoma Park, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Bier, M.D.				24a. REC'D BY REGISTRAR DEC 21 1957			
ADDRESS Washington San. & Hosp.				24b. REGISTRAR'S SIGNATURE J. William Rodd			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13275

CERTIFICATE OF DEATH

Reg. Dist. No.

133413

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. + Hosp.</u>		d. STREET ADDRESS <u>1302 Longfellow St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle Last <u>Logeman</u>		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/79</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Logeman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-09-6728A</u>	
17. INFORMANT <u>Adolph</u> Address <u>Wiece Mrs. Ziese 7121 8th St N.W. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ingestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>57</u> , to <u>Dec 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>57</u> , and that death occurred at <u>1:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. F. Ottman</u>		ADDRESS (Street, city or town, state) <u>401 Kennedy St NW Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u>		DATE SIGNED <u>Wash D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>2901 14th St. N.W. The S.H. Hines Co. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 18 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>John D. Dady</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13276 CERTIFICATE OF DEATH

Reg. Dist. No.

1334273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7216 Holly Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Caroline A. Longfellow</u>				4. DATE OF DEATH Month Day Year <u>Dec. 15, 1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/63</u>	9. AGE (In years last birthday) <u>94</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Longfellow & Rhodes Publishers, Iowa</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>David Longfellow</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bessie H. Guerrey</u>		Address <u>7216 Holly Ave. Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arterio Sclerosis (General)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs?</u> <u>10 yrs?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>15</u>	
20f. (City or town) <u>15</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1930</u> , 19 <u> </u> , to <u>12/15/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/15/57</u> , 19 <u> </u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Sims</u>				ADDRESS (Street, city or town, state) <u>1150 Connecticut Ave. N.W.</u>			
DATE SIGNED <u>12/19/57</u>							
PHYSICIAN'S NAME (Type) <u>W. B. Sims</u>				<u>1150 Conn. 1245</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>12/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>12/19/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Shelton Dady</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

DEC 19 1947

RECORDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13343

Reg. Dist. No. 246

13350

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown, Md.</u>	
f. STREET ADDRESS <u>R. 7. D. # 1</u>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Eugene</u> Last <u>Lowe, Jr.</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1925</u>
9. AGE (In years last birthday) <u>32 yrs.</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Germantown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard E. Lowe, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Nellie E. Farp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Lawrence D. Lowe, Germantown, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Infarction</u> 812X DUE TO <u>Basal Skull Fracture</u> 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Automobile accident</u> 2 days (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral fractures of tibia and fibula</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Pedestrian - Struck by auto</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:00</u> a.m. <u> </u> p.m. <u>12-26</u> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. Route 325</u>		20f. (City or town) <u>Bellevue</u> (County) <u>Montgomery</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-29-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-31-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Calithersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest G. Gartner.</u>		ADDRESS <u>Calithersburg.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
DATE <u>12-31-57</u>			

MEDICAL CERTIFICATION

7. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 3 1953

BUREAU V. R.

13360 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3725 Fessenden Street, N.W.	
3. NAME OF DECEASED (Type or print) First Mary Middle (nmn) Last LOWERY		4. DATE OF DEATH Month December Day 24 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 August 1856
9. AGE (In years last birthday) 101 yrs		10. IF UNDER 1 YEAR: Months 10 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas J. Shaunnessy		14. MOTHER'S MAIDEN NAME Elizabeth Shepherd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Daughter) Mrs. Sara S. Harrison (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6 December 19 57 to 24 December 19 57 , that I last saw the deceased alive on 24 December 19 57 , and that death occurred at 7:22A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, NMMC, Bethesda, Md. 12-24-57			
ACTUAL SIGNATURE John T. Craighead M.D. U.S. Naval Hospital, NMMC, Bethesda, Md.			
PHYSICIAN'S NAME (Type) John T. Craighead, LCDR, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-28-57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home, 5103 Wisconsin Ave.		24. REC'D BY REGISTRAR 12-24-57	
24b. REGISTRAR'S SIGNATURE Ray E. Carrelly			

R L. L. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

RECEIVED

DEC 30 1967

BUREAU V. A.

13277

CERTIFICATE OF DEATH

13345/73

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>2 days</u>				d. STREET ADDRESS <u>11507 Montgomery Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hazel Bernice Lubbes</u>				4. DATE OF DEATH Month Day Year <u>Dec. 28 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-15</u>	
9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>Henry Young</u>				14. MOTHER'S MAIDEN NAME <u>Grace Kidd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>9</u>		17. INFORMANT <u>Cheryl</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute viral hepatitis-</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Distinction between Toxic and</u> DUE TO (c) <u>serum hepatitis pending-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral edema</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 30</u> , 19 <u>57</u> , to <u>Dec. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 28</u> , 19 <u>57</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>13018 GEORGIA AVE SILVER SPRING, MD.</u> DATE SIGNED <u>12/27/57</u>							
ACTUAL SIGNATURE <u>A.W. Smith</u>				PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>12/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem. Prince Georges County, Md.</u>	
22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR <u>DEC 31 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John Brown Daddy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES

DEC 27 1947

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FBI
WASHINGTON

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13346

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 910 Ridgewood Street			
3. NAME OF DECEASED (Type or print) First Robert Middle Allen Last Maddocks				4. DATE OF DEATH Month December Day 27 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1924	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper				10b. KIND OF BUSINESS OR INDUSTRY Naval Academy		11. BIRTHPLACE (State or foreign country) California	
13. FATHER'S NAME Earlston L. Maddocks				14. MOTHER'S MAIDEN NAME Luella Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No				16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT MELANOMA with widespread met. 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from December 9, 19 57 , to December 27, 19 57 , that I last saw the deceased alive on December 27, 19 57 , and that death occurred at 2:45p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward A. Moore M.D.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 12/28/57	
PHYSICIAN'S NAME (Type) EDWARD A. MOORE, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cent		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Hupf				ADDRESS Annapolis		24a. REC'D BY REGISTRAR DATE 12/31/57	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

100 Y. E.

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13362

CERTIFICATE OF DEATH

Reg. Dist. No.

1334214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RDI Silver Spring, Bradley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRADFORD RUST Home</u>		d. STREET ADDRESS <u>Poolesville</u>	
3. NAME OF DECEASED (Type or print) <u>Charlotte</u> First <u>Martin</u> Middle <u></u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos GENIES</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Nursing Record</u>		Address <u>RDI Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Cecum</u> <u>153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition, anemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-19</u> , 19 <u>57</u> , to <u>12-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-19</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>RDI, Gaithersburg, Md.</u> DATE SIGNED <u>12-31-57</u>			
ACTUAL SIGNATURE <u>Clare C. Jackson</u> M.D.		PHYSICIAN'S NAME (Type) <u>RDI</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem Baptist.</u>	22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert K. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>1958</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Francis Pottery</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1941

1941

Page 4 of 4
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13363
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Its 1c, 11 7-1-12, 1-20-12 et
 CERTIFICATE OF DEATH

13348
 206

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>			
c. LENGTH OF STAY IN 1b <u>3 Yrs. 11 Mos.</u>				d. STREET ADDRESS <u>4823 Rugby Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Restmor San.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>McClure</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wht.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 March 1882</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Wm. John McClure</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mae Gessford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Rogers McClure (son)</u>		Address <u>4823 Rugby Ave. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> <u>502.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bronchiectasis</u> (c) <u>chronic emphysema</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 years</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease with cong. Aortic valve</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut M.D.</u>				ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut M.D.</u>				DATE SIGNED <u>Dec 22</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				24a. REC'D BY REGISTRAR <u>Bureau M. Thompson</u>		24b. REGISTRAR'S SIGNATURE	
Address <u>Bethesda, Md.</u>				DATE <u>12-24-57</u>			

BUREAU V. S.

DEC 27 19

RECEIVED

13364 CERTIFICATE OF DEATH

13349

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Suburban-Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5346 Pooks Hill Ct</u>	
3. NAME OF DECEASED (Type or print) <u>McCullough, Thomas Edward</u>		4. DATE OF DEATH <u>DEC 29 1957</u>	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 28, 1957</u>
9. AGE (In years last birthday) <u>Newborn</u>		IF UNDER 1 YEAR: Months <u>1</u> Days <u>14</u> Hours <u>14</u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Harry J. McCullough</u>		14. MOTHER'S MAIDEN NAME <u>Ann Copp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harry J. McCullough</u>		Address <u>5346 Pooks Hill Ct. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>176X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>35 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC 28, 1957</u> to <u>DEC 29, 1957</u> , that I last saw the deceased alive on <u>DEC 29, 1957</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Ira W. Pearlman</u> M.D.		ADDRESS (Street, city or town, state) <u>4700 BRADLEY BLVD</u> DATE SIGNED <u>CHERRY CHASE 15/58</u>	
PHYSICIAN'S NAME (Type) <u>DR. IRA W. PEARLMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/2/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>7557 Wis. Ave. Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 12-31-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

2074 376 XVO

RECEIVED

JAN 3 1958

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

13350

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 47 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Wilson c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilson d. STREET ADDRESS Route #4 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Willie James MEADOWS		4. DATE OF DEATH Month Day Year December 26 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 September 1896
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocer	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Luther MEADOWS		14. MOTHER'S MAIDEN NAME Daisy GRIMSLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 3-5-18 to 3-1-19		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Daughter Sarah A MEADOWS		Address Washington, D.C. 3200 16th St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocardial infarction DUE TO Coronary atherosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 November, 1957 , to 26 December, 1957 , that I last saw the deceased alive on 26 December, 1957 , and that death occurred at 1:33 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert P. Dobbie, Jr.		M.D. U.S. Naval Hospital, NNMC, Bethesda Md. 12-27-57	
PHYSICIAN'S NAME (Type) Robert P. Dobbie, Jr. CDR, MC, USN U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-29-57	22c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery	22d. LOCATION (City, town, or county) (State) Wilson, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Hunts Funeral Home		ADDRESS 115 N. Tarboro St. Wilson, N.C.	
24a. REC'D BY REGISTRAR ONE 12-27-57		24b. REGISTRAR'S SIGNATURE Mary E. Farrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

DEC 30 1957

RECEIVED

13366

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			c. LENGTH OF STAY IN 1b 6 Yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7411 Wyndale Lane			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 7411 Wyndale Lane		
3. NAME OF DECEASED (Type or print) First Ella Middle Rourke Last Mee			4. DATE OF DEATH Month Dec. Day 28 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1866	9. AGE (In years last birthday) 91 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sterling, Illinois
13. FATHER'S NAME John Rourke			14. MOTHER'S MAIDEN NAME Mary Williams		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Mrs. C.F. Mueller			Address 7411 Wyndale La., Chevy Chase, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general and cerebral DUE TO (c) 10 years INTERVAL BETWEEN ONSET AND DEATH 3 mo.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. — 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov 30, 1951 , to Dec 28, 1957 , that I last saw the deceased alive on Dec 28, 1957 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1150 Connecticut Ave., N.W., Wash. 6, D.C. DATE MOVED Dec 28, 1957					
ACTUAL SIGNATURE Frank S. Bacon			M.D. 1150 Connecticut Ave., N.W., Wash. 6, D.C.		
PHYSICIAN'S NAME (Type) Frank S. Bacon			ADDRESS 1150 Connecticut Ave., N.W., Wash. 6, D.C.		
22a. BURIAL, CREMATION, or TRANSIT Burial		22b. DATE THEREOF 12/31/57		22c. NAME OF CEMETERY OR CREMATORY Calvary	
22d. LOCATION (City, town, or county) (State) Sterling, Illinois					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.			24a. REC'D BY REGISTRAR DATE 2-31-57		
			24b. REGISTRAR'S SIGNATURE Fannie M. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1888

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germananton</i>		c. LENGTH OF STAY IN 1b <i># 73 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home</i>		d. STREET ADDRESS <i>—</i>	
3. NAME OF DECEASED (Type or print) <i>William Frederick Metz</i> First Middle Last		4. DATE OF DEATH <i>Dec-21-1957</i> Month Day Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec-23-1882</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR <i>11</i> Months <i>28</i> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farming, carpentry</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm, home</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Enock Metz</i>		14. MOTHER'S MAIDEN NAME <i>Francis Rebecca Snyder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>577-07-3726</i>	
17. INFORMANT <i>Mary M. Horton, Germananton, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute heart failure</i> 44- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Chronic myocardial insufficiency</i> DUE TO (c) <i>High arterial tension, periodically</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15-30 minutes</i> <i>3 years</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March</i> , 1952, to <i>Dec-21-</i> , 1957, that I last saw the deceased alive on <i>Dec-19-</i> , 1957, and that death occurred at <i>1 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i>		ADDRESS (Street, city or town, state) <i>7-Brooks Ave., Gaithersburg, Md.</i>	
PHYSICIAN'S NAME (Type) <i>William C. Miller</i>		DATE SIGNED <i>Dec-23-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-23-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Germananton Md-</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Garton Gaithersburg, Md.</i>		24a. REC'D BY REGISTRAR <i>1957</i>	24b. REGISTRAR'S SIGNATURE <i>Abner G. Cook</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13368

11-13-23 12-27-57

Reg. Dist. No. 214

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 yrs</u>		d. STREET ADDRESS <u>9921 Rogart Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9921 Rogart Rd</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Preston Ellsworth Miller</u>	4. DATE OF DEATH <u>Dec 20</u> 1957	5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>2-20-1889</u>	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>68 4/11</u> yrs	10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>20</u> Hours <u>11</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of -- golf driving Range</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas E. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Glosbach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Police Bureau</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic Hemorrhage</u>			
DUE TO (b) <u>shot gun wound thru left chest</u>			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Self inflicted shot gun wound</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner & Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DEC 23</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO DEPUTY MEDICAL EXAMINER: This official should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

DOMINIC V. S.

— 1957 —

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

214

13369

1. PLACE OF DEATH a. COUNTY <i>Montg.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>MONTG.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>512 Mansfield Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>LOUIS</i> Middle <i>MOGIN</i> Last		4. DATE OF DEATH Month <i>Dec</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UPHOLSTERER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-48-3176</i>	
17. INFORMANT <i>LESTER E MOGIN</i>		Address <i>512 MANSFIELD RD. SPRING</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO <i>or Hypertension</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>ca 6 hours</i> <i>3. - min</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>January 15, 1942</i> , to <i>Nov. 3, 1957</i> , that I last saw the deceased alive on <i>Nov. 23, 1957</i> , and that death occurred at <i>7:30 A.M.</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>H. Einstein</i>		M.D. <i>204 One St. N.W.</i>	
PHYSICIAN'S NAME (Type) <i>HUGO EINSTEIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12/3/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GEO. WASH. CEM. INC</i>	22d. LOCATION (City, town, or county) (State) <i>Hyattsville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gordberg Funeral Home, Wash. D.C.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>12/6/57</i>
		24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A P.

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13278

CERTIFICATE OF DEATH

Reg. Dist. No.

13355 *Dr 3*

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				d. STREET ADDRESS 8704 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle PAUL Last MOON				4. DATE OF DEATH Month DEC. Day 10 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 28, 1894	
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Mgr. - Printing Company				10b. KIND OF BUSINESS OR INDUSTRY New York		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Arthur Paul Moon				14. MOTHER'S MAIDEN NAME Mary Labery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO 207-07-4896		17. INFORMANT Miss Joan M. Moon, 8704 Colesville Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 148X DUE TO Terminal Cancer - lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal Cachexia DUE TO Bronchopneumonia (c) Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mos 1 wk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 411X				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Silver Spring, Md	
21. I certify that I attended the deceased from May 7 , 1945, to Dec 10 , 1957, that I last saw the deceased alive on Dec 10 , 1957, and that death occurred at 6:10 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 134 Edsforth Dr Silver Spring Md			
ACTUAL SIGNATURE Kenneth F. Laughlin M.D.				DATE SIGNED 12-10-57			
PHYSICIAN'S NAME (Type) KENNETH F. LAUGHLIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/13/57		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Lawrence S. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DEC 13 1957	
				24b. REGISTRAR'S SIGNATURE J. Nelsonaddy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEPT. OF
S. A. S.

CERTIFICATE OF DEATH

13356
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE West Virginia		b. COUNTY West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 131 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Skelton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 35		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Anna		Middle Marie		Last Moore	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1926	
						9. AGE (In years last birthday) 31 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. McGhee				14. MOTHER'S MAIDEN NAME Minnie B. Hyatt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 235-44-0884		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia + Pericardial effusion 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2° to Extensive metastatic disease DUE TO (c) Carcinoma of Breast - metastatic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491 X INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 20, 1957 to December 29, 1957 , that I last saw the deceased alive on December 29, 1957 , and that death occurred at 5:55 A.M. , from the causes and on the date stated above 4:55 A.M. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/29/57 ACTUAL SIGNATURE S.M. Kahn M.D. M.D. The Clinical Center PHYSICIAN'S NAME (Type) S.M. Kahn National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Bur-Transit		12/30/57		Mt. Tabor		Beckley, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-31-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

VS A15 (4)
15 9/5

BUREAU V. T.

144 3 1953

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13371

CERTIFICATE OF DEATH

13357
211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSTOWN</u>				c. LENGTH OF STAY IN 1b <u>14 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				d STREET ADDRESS <u>2 HYATTSTOWN</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY</u> <u>ETTA</u> <u>MULLIGAN</u>				4. DATE OF DEATH Month Day Year <u>DEC.</u> <u>3.</u> <u>1957</u>			
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>MAR. 16-1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MD. MONTGOMERY</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>NATHAN KINNA</u>			14. MOTHER'S MAIDEN NAME <u>REBECCA PICKENS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>GAIL GAIL KELLEY GREAT FALLS, IND.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>6 in. of small intestine with generalized metastases</u> DUE TO (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>Jan. 16</u> , 19 <u>50</u> , to <u>Dec. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 27</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>James P. Kern</u> M.D. <u>James P. Kern</u> <u>1-3-57</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>11-3-1957</u>		<u>METHODIST CHURCH</u>		<u>HYATTSTOWN</u>		<u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Burdette Hyattstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Burdette</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

THE AD-ON

13372

CERTIFICATE OF DEATH

13358 214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write nearest town) <u>Bensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>		d. STREET ADDRESS <u>8516-14th Ave.</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>NALLEY</u> Last <u>NALLEY</u>		4. DATE OF DEATH Dec. 26 1957	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Flaith</u>		14. MOTHER'S MAIDEN NAME <u>Emstern Snetzner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Louise A. Jones</u> Address <u>8516-14 Ave Hyattsville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIO-SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EPILEPSY</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JUNE 16, 1951</u> to <u>DEC. 26, 1957</u> , that I last saw the deceased alive on <u>Dec. 26, 1957</u> , and that death occurred at <u>7:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 New York Ave. Wash. D.C.</u> DATE SIGNED <u>12/26/57</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Seiers Sons Co</u> ADDRESS <u>3605-14 St Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Francis Pitter</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JFC 50 1957

RECEIVED

101 101

13373

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md. (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxen Hill</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>5220 Birchwood Dr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNMC, Bethesda Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Reginald</u> Last <u>NILSSEN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 January 1957</u>
9. AGE (In years lost birthday) yrs. <u>11</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ragnar Nils NILSSEN</u>		14. MOTHER'S MAIDEN NAME <u>Ernestine H. NUTH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Ragnar Nils NILSSEN Same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Congenital Heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 December, 1957</u> , to <u>28 December, 1957</u> , that I last saw the deceased alive on <u>28 December, 1957</u> , and that death occurred at <u>9:06 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Adam J Thorp Jr</u> M.D. <u>U.S. Naval Hospital, Bethesda Md. 13-30-57</u>			
PHYSICIAN'S NAME (Type) <u>A.T. THORP JR LT MC USN</u>		<u>U.S. Naval Hospital, Bethesda Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Georgia Ave. N.W. WASH. D.C.</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13279

CERTIFICATE OF DEATH

13360

Reg. Dist. No. 223

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o STATE <u>MD.</u> b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pick Haven</u>		d. STREET ADDRESS <u>Rittenhouse</u>	
3. NAME OF DECEASED (Type or print) <u>Hettie</u> First <u>NORTON</u> Middle <u>R.</u> Last		4. DATE OF DEATH <u>Dec. 20</u> Month <u>Dec.</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-84</u>
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lulus Kidwell</u>		14. MOTHER'S MAIDEN NAME <u>May E. Geyman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>[If yes, give war or dates of service]</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Chas M. B. Schaff</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>416X</u> DUE TO <u>Hypertensive Heart Disease - 72 hrs. prior to death</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension 202/105</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4</u> 1955, to <u>Dec 19</u> 1957, that I last saw the deceased alive on <u>Dec 19</u> 1957, and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas H Wol. Hon</u> M.D.		ADDRESS (Street, city or town, state) <u>500 Hollywood St NE</u> DATE SIGNED <u>12/1/57</u>	
PHYSICIAN'S NAME (Type) <u>Chas H Wol. Hon</u>		Mark De	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Calverton Manor MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Lee & Son</u> ADDRESS <u>300 474 N.E. Wash.</u>		24a. REC'D BY REGISTRAR <u>DEC 23 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>E. J. Ladd</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

13374

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
c. LENGTH OF STAY IN 1b 2 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10707 Amhurst Ave.				d. STREET ADDRESS 10707 Amhurst Ave.			
				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ICIE Middle MAY Last OFFUTT				4. DATE OF DEATH Month DEC. Day 13 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/89	
				9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME J. H. A. Brown				14. MOTHER'S MAIDEN NAME Margaret E. Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) III (If yes, give war or dates of service)				16. SOCIAL SECURITY NO none		17. INFORMANT Address Mr. Reginald J. Offutt, 10707 Amhurst Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Pharynx with Metastasis DUE TO (b) Malnutrition DUE TO (c) 14 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/4 1956 to 12/13 1957 that I last saw the deceased alive on 12/13/57 and that death occurred at 1A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John J. Curry M.D.				ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md			
PHYSICIAN'S NAME (Type) JOHN J. CURRY				DATE SIGNED 12/13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/16/57		22c. NAME OF CEMETERY OR CREMATORY QUEEN'S POINT CEMETERY		22d. LOCATION (City, town, county) (State) KEYSER, WEST VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Rumphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DEC 16 1957		24b. REGISTRAR'S SIGNATURE Frances Potter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

DEC 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13375

CERTIFICATE OF DEATH

Reg. Dist. No.

13362

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence/before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle G Last Paden		4. DATE OF DEATH Month December Day 13 Year 1957					
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 29, 1903	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ext. Operator		10b. KIND OF BUSINESS OR INDUSTRY Ext.		11. BIRTHPLACE (State or foreign country) Hagerstown - Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Paden			14. MOTHER'S MAIDEN NAME Harriet Troninger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT W. G. Paden (Wife)			Address Spencerville Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/13 , 19 57 , to 12/13 , 19 57 , that I last saw the deceased alive on 12/13 , 19 57 , and that death occurred at 9:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. D. Bonifant M.D. Samuel S. Spang M.D. 12/14/57 PHYSICIAN'S NAME (Type) A. D. BONIFANT							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF DEC 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		22d. LOCATION (City, town, or county) (State) Sandy Mount, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. H. H.				ADDRESS 254 Carroll St.		24b. REGISTRAR'S SIGNATURE Estimate Lowery	

Coroner notified by hospital and approved, by Dr. Broschart

RECEIVED
J. S.

37

1908
J. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 246

13376

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Potter</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>11 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galeton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>112 - 1ST ST.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Antonio</u> Middle <u>Pagano</u> Last <u>Pagano</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Naples, Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Vincent Pagano</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> If yes, give war or date of service	
16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Doris B. Pagano</u> Address <u>7036 Strathmore Chevy Chase, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>583x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute cholangitis; jaundice; liver failure</u> (c) <u>Acute cholecystitis; pancreatitis; cholangitis; hepatic glandular - Post operative</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hepatitis - mild - 25 yrs. previous</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-20, 1957</u> , to <u>12-31, 1957</u> , that I last saw the deceased alive on <u>12-30, 1957</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arch L. Riddick</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1835 E. 5th St. NW. Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>ARCH L. RIDDICK MD</u>		<u>1835 E. 5th St. NW. WASH DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Hill</u>	22d. LOCATION (City, town or county) (State) <u>Galeton, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 2-51-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 3 1933

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

133647

13377

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>12 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		d. STREET ADDRESS <u>Ellicott City</u>	
3. NAME OF DECEASED (Type or print) <u>Mattie</u> First <u>Patterson</u> Middle <u></u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1896</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		9. AGE (In years last birthday) <u>61</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Will Newton</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis + Hypertension</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-12-57</u> , 19 <u>57</u> , to <u>12-13-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-12-57</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12-13-57</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. Yates, M.D.</u>		<u>Olney, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swords</u>		ADDRESS <u>Rockville, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>DEC 19 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>Antonia Lawley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13378 CERTIFICATE OF DEATH

13365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON, MARYLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON, MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10409 PARKWOOD DRIVE</u>		d. STREET ADDRESS <u>10409 PARKWOOD DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>MARY</u> Last <u>Payne</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23rd, 1881</u>
9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, DIST. OF COL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT HOY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HOY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>MR. ROBERT PAYNE (SON)</u>		<u>KENSINGTON, MARYLAND</u> <u>10409 PARKWOOD DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diverticulitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> to <u>Dec 14</u> , 1957, that I last saw the deceased alive on <u>Dec 14</u> , 1957, and that death occurred at <u>7:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10511 Summit Ave 12/14/57</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		<u>Kensington, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson, Jr.</u>		ADDRESS <u>1300 - V St N.W.</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Tally</u>
		24a. REC'D BY REGISTRAR <u>DEC 17 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1954

100

13379

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE OHIO b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMILTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8319 Piney Branch Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pauline L. Pepper		4. DATE OF DEATH Month DECEMBER Day 16 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 19, 1873
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) TRENTON, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VALENTINE LAUBACH		14. MOTHER'S MAIDEN NAME MARIA SCHAFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Stanley G. Cook, 8319 Piney Branch Rd. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC (ANGIOVASCULAR) DISEASE DUE TO (c) ARTERIOSCLEROTIC (GENERALIZED)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 30 years 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ++x BRONCHOPNEUMONIA, STATIC		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 5, 1957 , to Dec 16, 1957 , that I last saw the deceased alive on Dec 14, 1957 , and that death occurred at 11:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George P. George		DATE SIGNED 9404 Glenville Rd. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) GEORGE P. GEORGE			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 12/17/57	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DEC 20 1957	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Frances Pattery	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

DEC 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13380

CERTIFICATE OF DEATH

Reg. Dist. No.

13367/6

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X7. Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>13707 Shepherd St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lewis Harvey Phelps Sr.</u>		4. DATE OF DEATH Month Day Year <u>12 31 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/75</u>
9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant Automobile Parts</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jesse O. Phelps</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Cadle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert E. Phelps</u>		3707 ^{Address} Shepherd St. <u>Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 congestive heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1941</u> to <u>Dec 31, 1957</u> , that I last saw the deceased alive on <u>12/31, 1957</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>		M.D. <u>7852 16th NW Wash DC</u> DATE SIGNED <u>12/31/57</u>	
PRESTIGER NAME (Type) <u>H. F. Kreuzburg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>DATE 6 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

U.S. AIR FORCE

100-100000

FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13381

13368

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. General Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
f. STREET ADDRESS 5711 Ridgeway Ave.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Robert Pine		4. DATE OF DEATH Dec. 19, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX 3/8/18
9. AGE (In years last birthday) 39 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clifton R. Pine	
14. MOTHER'S MAIDEN NAME Doris J. Bealmear		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Police Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Fra nk J. Broschart M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Fra nk J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/19/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. -Transit	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY Maple Grove	22d. LOCATION (City, town, or county) (State) Granville, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24. REGISTRAR'S SIGNATURE D. Lawler	

DEC 23 1957

95

RECEIVED

NOV 28 1957

RECEIVED

13382

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

216

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 4 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville RFD # 1 d. STREET ADDRESS Piney Meeting House Road	
3. NAME OF DECEASED (Type or print) Frances S. Plummer		4. DATE OF DEATH Dec. 8, 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/1895
9. AGE (in years last birthday) 62 yrs		10. IF UNDER 1 YEAR: Months 0 Days 0	
11. IF UNDER 24 HRS: Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Sebring		14. MOTHER'S MAIDEN NAME Carrie Hickenlooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. George P. Plummer-Item # 2	
17. INFORMANT George P. Plummer-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Tracheo-bronchitis (c) Bichloride of Mercury Poisoning PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 1/2 hrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Taken a large quantity of bichloride of mercury tablets	
20c. TIME OF INJURY 7:00 a.m. 12/8/57	20d. INJURY OCCURRED While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Rockville (County) Montg. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 12/8/57	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/10/57	22c. NAME OF CEMETERY OR CREMATORY Potomac Ch. Cem.	22d. LOCATION (City, town, or county) Potomac, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR 12/11/57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 10 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13383
CERTIFICATE OF DEATH

13370218
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>n Germantown (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Germantown, R. F. D. # 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>[REDACTED]</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES MAE POSEY</u>		4. DATE OF DEATH Month Day Year <u>Dec. 12, 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William J. Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Diggins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Bernice Williams.</u>		Address <u>Germantown, Md. Route 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary carcinoma bladder</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>18 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6-3</u> , 19 <u>57</u> to <u>12-12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-8</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. M. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u>	
DATE SIGNED <u>12/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bells Chapel,</u>
22d. LOCATION (City, town, or county) <u>Dickerson, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Alvord G. Hooker</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A 1

REC 19 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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13280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Cleveland Avenue		d. STREET ADDRESS 5 Cleveland Ave.	
3. NAME OF DECEASED (Type or print) First JAMES Middle EDGAR Last PROVANCE		4. DATE OF DEATH Month DEC. Day 11 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/95
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer (District Highway Planning)		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James K. Provance		14. MOTHER'S MAIDEN NAME Bessie Provance	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO. 218-24-3364	
17. INFORMANT Mrs. Florence R. Provance, 5 Cleveland Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive Respiratory Paralysis DUE TO Angiographic Contrast Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 27 months DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 27 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/12/55 , 19 55 , to 12/11 , 19 57 , that I last saw the deceased alive on 12/11 , 19 57 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis X. Richardson M.D.		ADDRESS (Street, city or town, state) 1717 Ave. L. Ave. S.W. DATE SIGNED 12/11/57	
PHYSICIAN'S NAME (Type) FRANCIS X. RICHARDSON		U.S. H. & A. S. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/13/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DEC 13 1957		24b. REGISTRAR'S SIGNATURE J. Nelson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

RECEIVED

13384

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>6 mos. 24 days</u>				d. STREET ADDRESS <u>4700 Connecticut Ave.,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Wills</u> Last <u>ROBERSON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 Sept. 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Irving Cross WILLS</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Louise COBB</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>(Daughter) Mrs. Margo OSBORNE (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Rectum with Metastases</u>							
DUE TO (b) <u> </u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 May</u> 19 <u>57</u> , to <u>6 December</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6 December</u> 19 <u>57</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. J. Cales</u>				DATE SIGNED <u>12-6-57</u>			
PHYSICIAN'S NAME (Type) <u>R. J. CALES, LCDR, MC, USN</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hines Co.</u>				24a. REC'D BY REGISTRAR DATE <u>12-6-57</u>			
23. ADDRESS <u>S. H. HINES, 2901 14th St., N.W. Washington, D.C.</u>				24b. REGISTRAR'S SIGNATURE <u>May E. Parsally</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROMERO V. E.

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W. E. R.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRONIA PARK</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM Hosp.</u>		d. STREET ADDRESS <u>6902 PINEY BRANCH RD</u>	
3. NAME OF <u>THOMAS</u> First Middle Last		4. DATE OF DEATH <u>Dec. 20</u> Month Day Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1871</u>
9. AGE (In years, last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GOV. EMPLOYEE of FEDERAL GOVT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS ROBERTSON</u>		14. MOTHER'S MAIDEN NAME <u>JANE TURNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. MARY B. ROBERTSON</u> Address <u>6902 PINEY BRANCH RD D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-Vascular-Renal Syndrome</u> DUE TO (c) <u>(Hypertensive Crisis)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Sev. weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia; and aphasia</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While of work Not while of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 1, 1957</u> to <u>Dec. 20, 1957</u> , that I last saw the deceased alive on <u>Dec. 18, 1957</u> , and that death occurred at <u>10:50</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lynwood Heiges</u> M.D.		ADDRESS (Street, city or town, State) <u>6940 Piney Branch Rd. NW</u>	
PHYSICIAN'S NAME (Type) <u>LYNWOOD HEIGES, M.D.</u>		DATE SIGNED <u>12/20/57</u>	
22a. BURIAL, CREMATION, <u>CREMATION</u>	22b. DATE THEREOF <u>DEC 21, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>PENNA AVE SE EAST SUITLAND, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Rogers</u> ADDRESS <u>254 Carroll St. NW</u>		24. REC'D BY REGISTRAR DATE <u>12/24/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNNAN V. S.

DEC 1957

RECEIVED

13385

CERTIFICATE OF DEATH

13374

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>18713 Cameron St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Lurie</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1884</u>	9. AGE (In years last birthday) <u>73</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
13. FATHER'S NAME <u>Jonah Lurie</u>				14. MOTHER'S MAIDEN NAME <u>Racheal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Pauline A. Robinson</u> Address <u>S.S. 8712 Cameron St.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>							<u>1 Hour</u>
464X DUE TO (b) <u>Phlebotrombosis</u>							<u>1 day</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Gall Bladder with Abdominal Metastasis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12 December 1957</u> , to <u>9 December 1957</u> , that I last saw the deceased alive on <u>9 December 1957</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>8641 Cuyesville Rd. Silver Spring, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>B. Eig</u>				DATE SIGNED <u>DEC 11 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Temple Beth Israel Cemetery</u>		22d. LOCATION (City, town, or county) <u>Sharon, Pa.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Denzonsky & Sons</u> ADDRESS <u>3501 14th St., N.W.</u>				24a. REC'D BY REGISTRAR <u>C 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

RECEIVED

BUREAU V. S.

13282

CERTIFICATE OF DEATH

13375
Reg. Dist. No 223

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>D.C.</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>	
c. LENGTH OF STAY IN 1b <u>2 months</u>		d. STREET ADDRESS <u>1342 Irving St., N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Veronica Louise</u> First Middle Last		4. DATE OF DEATH <u>Dec. 19</u> Month Day Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1889</u> 9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>
13. FATHER'S NAME <u>John B. Rucca</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
14. MOTHER'S MAIDEN NAME <u>Asunta Cassa sa</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>Oct 19, '57</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-19-1957</u> to <u>12-19-1957</u> that I last saw the deceased alive on <u>12-19-1957</u> and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park (809 Davis Ave) Md</u> DATE SIGNED <u>12/19/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	22b. DATE THEREOF <u>12/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St. N.W. Washington, D.C.</u>		24. REC'D BY REGISTRAR <u>DEC 19 1957</u> DATE	24b. REGISTRAR'S SIGNATURE <u>J. W. Dodd</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 28 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13376 *211*

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10200 Day Ave.		d. STREET ADDRESS 10200 Day Ave	
3. NAME OF DECEASED (Type or print) Mabel M. Rogers		4. DATE OF DEATH Month Dec. Day 11 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/84
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Brahler		14. MOTHER'S MAIDEN NAME Elizabeth Leimbach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mabel C. Rogers, Same as Item 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO (c) 420.1 DUE TO cause last.			
INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/12/ 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-14-57	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cem.	22d. LOCATION (City, town, or county) (State) Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Thomas B. Hanlon		24a. REC'D BY REGISTRAR 16 1957	
ADDRESS 3831 Ga. Ave. N.W.		24b. REGISTRAR'S SIGNATURE Frances P. Perry	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13337

CERTIFICATE OF DEATH

13377

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9301 Milroy Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Foster Jackson Rowen				4. DATE OF DEATH Month Day Year December 21 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1896	
9. AGE (In years last birthday) 61 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Detective		10b. KIND OF BUSINESS OR INDUSTRY Investigation		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James David Rowen		14. MOTHER'S MAIDEN NAME Nellie K. Balthis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Cirrhosis with Fatty change 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Jaundice of Biliary tissues DUE TO (c) 13 day INTERVAL BETWEEN ONSET AND DEATH Chronic						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 9, 1957 , to December 21, 1957 , that I last saw the deceased alive on December 21, 1957 , and that death occurred at 1:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12-21-57 The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THERETO 12/23/57		22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		22d. LOCATION (City, town, or county) (State) Charles Town, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE S. N. Jones ADDRESS 2901 14th St NW				24a. REC'D BY REGISTRAR DATE 23 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 27 1957

BUREAU V. S.

13388

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, d. STREET ADDRESS 3114 Homewood Parkway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Elmer RUTTKAY				4. DATE OF DEATH Month December Day 6 Year 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 January 1920		9. AGE (In years last birthday) 37 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Art Director Republican Committee				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin Ruttkay				14. MOTHER'S MAIDEN NAME Elizabeth METZ					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 1942 to 1945				16. SOCIAL SECURITY NO. unknown		17. INFORMANT (Wife) Mary K. RUTTKAY (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Metastatic Carcinoma DUE TO (c) Carcinoma Bronchogenic								INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 mos - unk -	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 October, 1957 , to 6 December, 1957 , that I last saw the deceased alive on 6 December, 1957 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-7-57									
ACTUAL SIGNATURE [Signature] NAME (Type) T.S. DUNN JR. LT MC USN				M.D. U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-10-57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS 7557 Wisconsin Ave. Bethesda Md.				24a. REC'D BY REGISTRAR 12-7-57		24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUCHANAN K. S.

DEC 1

LIBRARY
OF THE
U.S. HOUSE OF REPRESENTATIVES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13283

CERTIFICATE OF DEATH

13329 7
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>6 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Agnes (NMN) Schneider</u>				4. DATE OF DEATH <u>December 4 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry George</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth McCarra</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Agnes Jones</u> Address <u>9209 Flower Ave., S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> DUE TO <u>Carcinomatous of abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon</u> (c) <u>Carcinoma of Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>15 months</u> <u>15 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 6, 1957</u> , to <u>Dec 4, 1957</u> , that I last saw the deceased alive on <u>Dec 4, 1957</u> , and that death occurred at <u>8:25 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare M.D.</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>12/4/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>8434 La Ave SE</u>				24a. REC'D BY REGISTRAR <u>DEGG</u> DATE <u>12/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Saddy</u>	

BUREAU V. 5

DEC 6

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13389

CERTIFICATE OF DEATH

Reg. Dist. No.

13389 217

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GEN. HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING,			
f. STREET ADDRESS 14,112 COLESVILLE ROAD				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE E. SCHULTZ				4. DATE OF DEATH Month Day Year DEC. 24 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/11/98	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT (retired)				10b. KIND OF BUSINESS OR INDUSTRY R.F.C.			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN WILLIAM SCHULTZ				14. MOTHER'S MAIDEN NAME ADA CURTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 579-09-8170		17. INFORMANT Address Mrs. Marian L. Schultz, 14,112 Colesville Road Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial insufficiency 4x0.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with DUE TO (c) myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 12 months 4 years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 21 , 19 57 , to Dec 24 , 19 57 , that I last saw the deceased alive on Dec 23 , 19 57 , and that death occurred at 3:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Clara H. Traum M.D. 8237 Georgia Ave Silver Spring, Md. 1/4/58							
ACTUAL SIGNATURE AARON H. TRAUM				PHYSICIAN'S NAME (Type) AARON H. TRAUM			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/27/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DEC 26	
				24b. REGISTRAR'S SIGNATURE Gertrude Lowery			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 27 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13390

CERTIFICATE OF DEATH

13381

Reg. Dist. No. 2/8

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Maryland	
c. LENGTH OF STAY IN 1b 2 years		d. STREET ADDRESS Gaithersburg, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Emory Last Scott		4. DATE OF DEATH Month December Day 16 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 16, 1870
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Tazwell, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Tivis Moore		14. MOTHER'S MAIDEN NAME Sarah W. Caldwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT None		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute heart failure 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bilateral pneumonia DUE TO (c) Cancer of the head of the pancreas			
INTERVAL BETWEEN ONSET AND DEATH immediate 12-4-57			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-11 , 19 56 , to 12-16 , 19 57 ; that I last saw the deceased alive on 12-11 , 19 57 , and that death occurred at 1:30P M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Sarah E. Glover		M.D. 4208 Anthony ST. Kensington Md 12/16/57	
PHYSICIAN'S NAME (Type) Sarah E. Glover			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-19-57	Ward's Chapel	Holbrook, Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight - Cydenville, Md.		24. REGISTRAR'S SIGNATURE Alvenerda Cooke	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

READ V. S.

RECEIVED

13391 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY Montgomery				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 601 19th Street, N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Middle Last Charles Joseph Shields				4. DATE OF DEATH Month Day Year December 25 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1897	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Management Consultant				10b. KIND OF BUSINESS OR INDUSTRY Army Intelligence		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Hugh J. Shields				14. MOTHER'S MAIDEN NAME Hannah Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I, WW II				16. SOCIAL SECURITY NO 187-01-5214			
17. INFORMATION The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hepatic insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hepatic metastases DUE TO (c) Gastric carcinoma						INTERVAL BETWEEN ONSET AND DEATH 6 wks. 1/2 yr. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19	
20f. (City or town) 19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from October 22 1957 to December 25 1957 that I last saw the deceased alive on December 25 1957 and that death occurred at 2:18 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/26/57 ACTUAL SIGNATURE Kurt W. Nohn M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Kurt W. Nohn, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		27-DEC-1957		ARLINGTON NATIONAL		ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi				ADDRESS 816 H. St. N.E. D.C.		24a. REC'D BY REGISTRAR DEC 30 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

13284

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 SCHAMORE AVE</u>		d. STREET ADDRESS <u>6600 7th St NW</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARA H E SHIPMAN</u>		4. DATE OF DEATH Month Day Year <u>Dec 26 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>OCT 14 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (in years last birthday) <u>91</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS T. TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET A. WHITE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>LOIS S BRIGGS</u>		Address <u>6600 7th St NW</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Heart Disease</u> 400.0 DUE TO <u>with acute congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Arteriosclerosis, Senility</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia - Dehydration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 18</u> , 19 <u>56</u> , to <u>Dec 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 24</u> , 19 <u>57</u> , and that death occurred at <u>3 PM</u> , from the cause and on the date stated above. ADDRESS (Street, city or town, state) <u>3601-4th St NW Washington 11 DC</u> DATE SIGNED <u>Dec 26-57</u>			
ACTUAL SIGNATURE <u>J. X. Courtney</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. X. COURTNEY MD</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Seccombe Home</u>		ADDRESS <u>4812 Spruce St Wash DC</u>	24a. REC'D BY REGISTRAR <u>C 331257</u>
24b. REGISTRAR'S SIGNATURE <u>W. L. Brown</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 30 1957

BUREAU Y.F.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13392

CERTIFICATE OF DEATH

13384 14

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b 10 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8804 Colesville Road				d. STREET ADDRESS 8804 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CATHERINE D. SIMPSON				4. DATE OF DEATH Dec. 13 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1879	
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Federalsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John M. Davis				14. MOTHER'S MAIDEN NAME Rhoda E. Noble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 249-09-8158D		17. INFORMANT Miss Dorothy V. Milbourne, 8804 Colesville Rd., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Oct 19 57 to 12/13 19 57 , that I last saw the deceased alive on 12/13/57 , 19 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud M.D.				ADDRESS (Street, city or town, state) 900 Colesville Rd, Silver Spring, Md.			
DATE SIGNED 12/14/57				PHYSICIAN'S NAME (Type) WILLIAM D. AUD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DEC 18	
24b. REGISTRAR'S SIGNATURE Frances Pattery							



RECEIVED

DEC

1947

13393

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 410 Fenwick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Elwood SMITH		4. DATE OF DEATH Month Day Year December 3 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 May 1918
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. SMITH		14. MOTHER'S MAIDEN NAME Maybelle GENTRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Mrs. Agnes Smith (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 December 19 57 to 3 December 19 57 , that I last saw the deceased alive on 3 December 19 57 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling M.D. U.S. Naval Hospital, Bethesda, Md. 12-4-57			
ACTUAL SIGNATURE C. U. Shilling		PHYSICIAN'S NAME (Type) C. U. SHILLING, LT, MC, USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-57	22c. NAME OF CEMETERY OR CREMATORY Mount Mariah Cemetery
22d. LOCATION (City, town, or county) (State) Camden, Arkansas		23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, 3072 M St., N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR 12-4-57		24b. REGISTRAR'S SIGNATURE Mary E. Ganssely	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR FORCE

1957

RECEIVED

13285

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

773

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 6 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7708 Takoma Ave.			e. STREET ADDRESS 7708 Takoma Ave.		e. IS RESIDENT ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) W. Wallace Smith		4. DATE OF DEATH Month Dec. Day 28 Year 1957		5. SEX male	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/2/1890	
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Gov. Acc. Office		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Miles Smith		14. MOTHER'S MAIDEN NAME Alice Farnsworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 173-09-1464		17. INFORMANT Address Alice Smith, Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Pulmonary emboli DUE TO (b) Bilateral Thrombo-phlebitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Struck by truck					INTERVAL BETWEEN ONSET AND DEATH sudden ? 11/12/57
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Trans urethral operation 12/10/57					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Was pedestrian struck by truck			
20c. TIME OF INJURY Month, Day, Year 9:45 a.m. 11/12/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	
20f. (City or town) Danville		20g. (County) Pa.		20h. (State) Pa.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/29/57	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS & BURIAL		22b. DATE THEREOF 12/31/57		22c. NAME OF CEMETERY OR CREMATORY NEW ROSEMONT CEMETERY	
22d. LOCATION (City, town, or county) BLOOMSBURG, PA.		22e. (State) Pa.		22f. REC'D BY REGISTRAR JAN 2 1958	
23. FUNERAL DIRECTOR'S SIGNATURE W. B. Rumphrey		ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE John D. Dady	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1910

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13394

CERTIFICATE OF DEATH

13387 216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 43 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 109 East Linden Street	
3. NAME OF DECEASED (Type or print) First Lynne Middle Ruth Last Sparks		4. DATE OF DEATH Month December Day 10 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1915
9. AGE (In years last birthday) 42 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Hofstetter		14. MOTHER'S MAIDEN NAME Paula Mueller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the left breast DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 days 1 1/2 yrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 28, 1957 to December 10, 1957 , that I last saw the deceased alive on December 10, 1957 , and that death occurred at 1:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12/10/57 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE <i>Lawrence Schlachter</i> M.D.			
PHYSICIAN'S NAME (Type) LAWRENCE SCHLACHTER, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	12/13/57	Arch. Hill Cemetery	Arlington Va
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Lowe</i>		ADDRESS Alexandria Va	24a. REC'D BY REGISTRAR DEC 13 1957
		24b. REGISTRAR'S SIGNATURE <i>Cessie Thompson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

U. S. DEPARTMENT OF JUSTICE

13395

CERTIFICATE OF DEATH

13388

Reg. Dist. No.

246

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Annandale d. STREET ADDRESS 906 West Estabrook Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last David Lee Sprague				4. DATE OF DEATH Month Day Year December 5, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 30, 1943	
9. AGE (In years last birthday) 13 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Lee N. Sprague				14. MOTHER'S MAIDEN NAME Mary Lowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 1044 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Valvulotomy Hypothermia DUE TO (c) Congenital Aortic Stenosis INTERVAL BETWEEN ONSET AND DEATH 10x10 min 3 min 13 years						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1, 1957 to December 5, 1957 that I last saw the deceased alive on December 5, 1957 and that death occurred at 12:51 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-5-57 ACTUAL SIGNATURE John A. Waldhausen M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) John A. Waldhausen, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL, ETC. Burial		22b. DATE THEREOF 12/6/57		22c. NAME OF CEMETERY OR CREMATORY Floral Gardens		22d. LOCATION (City, town or county) (State) Highpoint, N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 12-6-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10 AUG 1964

CERTIFICATE OF DEATH

13389

Reg. Dist. No.

13396

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearwater			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 2100 Palmetto Street			
3. NAME OF DECEASED (Type or print) First Isabelle Middle Bingham Last Stieg				4. DATE OF DEATH Month December Day 27 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1881	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) York, Pa. York County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. H. Griffith				14. MOTHER'S MAIDEN NAME Unknown Margaretta Layman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Forest G. Stieg Address Arlington, Virginia 2718 No. 18th St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Broncho pneumonia 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parotitis, left						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 26 , 19 57 , to Dec 27 , 19 57 , that I last saw the deceased alive on Dec 26 , 19 57 , and that death occurred at 4:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Ave Kensington, Md. DATE SIGNED 12/27/57							
ACTUAL SIGNATURE George Sharpe				PHYSICIAN'S NAME (Type) George Sharpe			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/30/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Prince Co - 2901-14th St N.W.				24a. REC'D BY REGISTRAR DEC 30		24b. REGISTRAR'S SIGNATURE Debbie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13397/6

13397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN IB <u>2 days</u>		d. STREET ADDRESS <u>8308 16th</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isabella Cutbertson Taylor</u>		4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Cutbertson</u>		14. MOTHER'S MAIDEN NAME <u>Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Robert G. Taylor</u>		Address <u>784 Fort...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Urterial obstruction</u> DUE TO (c) <u>Extension of Carcinoma of Cervix</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> <u>1956</u> to <u>Dec 7</u> <u>1957</u> , that I last saw the deceased alive on <u>Dec 7</u> <u>1957</u> , and that death occurred at <u>9:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William L. Howell</u>		M.D. <u>3562 Macomb St NW</u> <u>12/7/57</u>	
PHYSICIAN'S NAME (Type) <u>William L. Howell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Lawler's Sons</u>		ADDRESS <u>Wash. D.C.</u>	
24. REC'D BY REGISTRAR <u>DEC 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

SEARCH

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13398 CERTIFICATE OF DEATH

13391

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>x2</u> Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4705 Highland Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Childred</u> First <u>Harriette</u> Middle <u>Terry</u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 29, 1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government Serv.</u>	
11. BIRTHPLACE (State or foreign country) <u>Warren, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Morgan Davies</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mabel A. Davies (Sister)</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> 19 <u>36</u> , to <u>Dec</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 22</u> 19 <u>57</u> , and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8016 Kensington Rd Bethesda 14 Md</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Leo J. Donovan M.D.</u>		PHYSICIAN'S NAME (Type) <u>LEO J DONOVAN M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DA-24-57</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 27 1961

BUREAU OF

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13392

13399

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarey</u>				c. LENGTH OF STAY IN 1b <u>3 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>1400 29th St., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Katharine</u> Middle <u>J.</u> Last <u>Thayer</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2 - 1862</u>	9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Pease</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Phillip Thayer 1400 29th St. NW, Wash DC.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x</u> <u>hepatitis, arterio sclerosis</u> DUE TO (b) <u>uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>o. p.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Sep. 17</u> , 19 <u>57</u> , to <u>12/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>57</u> , and that death occurred at <u>9:00</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Bird</u>		M.D. <u>Sandy Sping</u>		ADDRESS (Street, city or town, state) <u>Prince Geo. Co. Md.</u>		DATE SIGNED <u>12/13/57</u>	
PHYSICIAN'S NAME (Type) <u>Walter E. Humphrey</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Dec 13, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) _____ (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave S.E. Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 16 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u>		

BUREAU V. S.

DEC 1 1901

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13400

CERTIFICATE OF DEATH

13393

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 hr. 15 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. STREET ADDRESS 102 Irvington Street,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle (nmn) Last THOMAS				4. DATE OF DEATH Month December Day 5 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 5, 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min	
						8 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Bernard Joshua THOMAS, Jr.				14. MOTHER'S MAIDEN NAME Patricia Ann Fox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (Father) Bernard J. Thomas, Br. (Same As #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Atelectasis 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 5 December 19 57 to 5 December 19 57 , that I last saw the deceased alive on 5 December 19 57 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-6-57							
ACTUAL SIGNATURE Adam G. Thorp Jr. M.D.							
PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.			
24a. REC'D BY REGISTRAR 12-6-57				24. REGISTRAR'S SIGNATURE Tracy E. Parrelly			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

REC

RECEIVED

13401

CERTIFICATE OF DEATH

13394

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE 2+ mrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 E. IRVING ST.		d. STREET ADDRESS REF 1 Box 90	
3. NAME OF DECEASED (Type or print) ALFRED First RAYMOND Middle TOLSON Last		4. DATE OF DEATH DEC. 31 Month 1957 Day Year	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 22, 1895 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET-MAKER		10b. KIND OF BUSINESS OR INDUSTRY LANSBURGH'S DEPT. D.C.	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE ALEXANDER TOLSON		14. MOTHER'S MAIDEN NAME MARGARET MCMAHON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 22012 3601	
17. INFORMANT MARGARET MCMAHON Address 11 E. IRVING ST. CHEVY CHASE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE 10490		INTERVAL BETWEEN ONSET AND DEATH 2 HRS. 36 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, modify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour None p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 21, 1957 to DEC 30, 1957 that I last saw the deceased alive on DEC 30, 1957 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver Jr.		M.D. Branch Ave. Clinton Md 12/31/57	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.		ADDRESS BRANCH AVE. CLINTON, MD. 12/31/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-4-58	22c. NAME OF CEMETERY OR CREMATORY St Peters Cem.	22d. LOCATION (City, town, or county) (State) WALDORF, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		24a. REC'D BY REGISTRAR WALDORE MD.	24b. REGISTRAR'S SIGNATURE Ben Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13395

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>2 mo</u>		d. STREET ADDRESS <u>14511 Coleville Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mairlea Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Treadway</u>		4. DATE OF DEATH <u>Dec 8</u> 1957	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1909</u>
9. AGE (In years last birthday) <u>48</u> yrs		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Decker</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mo</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
DUE TO (b) <u>Hypertension</u>			
DUE TO (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Several yrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BLRIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 11, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR <u>Dec 10, 1957</u>	
ADDRESS <u>Harlington, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Francis O. Patter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED 8-21

DEC

1954

182

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Rockville		c. LENGTH OF STAY IN 1b 6 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14901 Georgia Ave. St. Philomena's Rest Home		d. STREET ADDRESS 1717 - 31st St., S. E.	
3. NAME OF DECEASED (Type or print) HENRY T. TUCKER		4. DATE OF DEATH Month Dec. Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 30, 1873
9a. AGE (In years last birthday) 84 yrs.		9b. IF UNDER 1 YEAR Months 7 Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Dealer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry B. Tucker		14. MOTHER'S MAIDEN NAME Mary Ann Milford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Son		Address 1717-31st St., Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 400.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 20 Yrs 48 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 48 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-7-1955 to 12-13-1957 , that I last saw the deceased alive on 12-4-1957 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2205 Richland St., Silver Spring, Md. DATE SIGNED			
ACTUAL SIGNATURE Henry J. Kicherer M.D. 2205 Richland St., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) H. J. Kicherer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-16-57	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR DATE 12-17-57
		24b. REGISTRAR'S SIGNATURE Barrie L. ...	

VS AIS (4)
ISM 9/SS

REAU V. B.

1907

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RECEIVED

13286

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSPITAL				d. STREET ADDRESS 3620 KANAWHA ST. NW			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK COVER UPDIKE				4. DATE OF DEATH Month / Day Year 12 / 28 / 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-95	9. AGE (In years last birthday) 62 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVERNMENT CLERK				10b. KIND OF BUSINESS OR INDUSTRY Interior Dept. Retired Chief of Miscellaneous		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME BYRD UPDIKE				14. MOTHER'S MAIDEN NAME MARY LEACH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) ARMY 1st WW				16. SOCIAL SECURITY NO		17. INFORMANT HOSPITAL RECORD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive Cardiac Failure DUE TO (c) Heart Disease - Rheumatic						INTERVAL BETWEEN ONSET AND DEATH 14 days one week 3 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-14-57 , 19 57 , to 12-28 , 19 57 , that I last saw the deceased alive on 12-27- , 19 57 , and that death occurred at 4:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Takoma Park, Md DATE SIGNED 1/28/57							
ACTUAL SIGNATURE Robert A. Hare				PHYSICIAN'S NAME (Type) Robert A. HARE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE S.W. Home Co 2901-14th ST N.W. Wash., D.C.				24a. REC'D BY REGISTRAR DEC 30		24b. REGISTRAR'S SIGNATURE William A. Dady	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 30 1957

BUREAU V. S.

13404

Item 9 Film G223 12-30-57 et
CERTIFICATE OF DEATH

13398

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Year 6 mos. 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
f. STREET ADDRESS Route #2		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last URBAN		4. DATE OF DEATH Month December Day 16 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 February 1888
9. AGE (In years last birthday) 68 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John L. URBAN		14. MOTHER'S MAIDEN NAME Mary MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I&II		16. SOCIAL SECURITY NO. 577 42 3715	
17. INFORMANT (Wife) Carolyn M. URBAN (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Cerebro-Cardio-Vascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema, Atrial fibrillation DUE TO (c) Diffuse Cerebro-Vascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 June , 19 56 , to 16 Dec. , 19 57 , that I last saw the deceased alive on 15 December , 19 57 , and that death occurred at 3:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-16-57			
ACTUAL SIGNATURE Morris H. Lampert M.D.		U.S. Naval Hospital, Bethesda, Md.	
PRINTED NAME (Type) Morris H. Lampert, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-18-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Pumphrey		24a. REC'D BY REGISTRAR 12-16-57	24b. REGISTRAR'S SIGNATURE Mary Pumphrey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

070

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13405
Items 11 & 14 G224 1/6/58 STE CERTIFICATE OF DEATH

13399
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 12 hr. 30 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Portsmouth c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portsmouth d. STREET ADDRESS 4314 King Street, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harold (nmn) VAN HOOSE				4. DATE OF DEATH Month Day Year December 17 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 November 1910	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government		10b. KIND OF BUSINESS OR INDUSTRY State Department		11. BIRTHPLACE (State or foreign country) Pennsylvania Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George VAN HOOSE				14. MOTHER'S MAIDEN NAME Mary (last name unknown) Witten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO Unknown		17. INFORMANT (Wife) Sadie M. VAN HOOSE (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, subarachnoid DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension arterial, benign Hypertensive Vascular disease, benign INTERVAL BETWEEN ONSET AND DEATH 22 hrs ? years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 December 19 57 to 17 December 19 57 , that I last saw the deceased alive on 16 December 19 57 , and that death occurred at 12:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-17-57							
ACTUAL SIGNATURE W. B. Ingram				M. D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) W. B. INGRAM, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Portsmouth, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-17-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Purcell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1941

DEC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13406

CERTIFICATE OF DEATH

13400

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN TB 2-144			
d. NAME OF HOSPITAL (If not in hospital, give street address) Kensington Gardens Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Walter Last Vuncanon				4. DATE OF DEATH Month December Day 1 Year 1957			
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Lumberman		10b. KIND OF BUSINESS OR INDUSTRY So. Pine Lumber		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. H. Vuncanon				14. MOTHER'S MAIDEN NAME Martha E. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Martha Reixach-Item# 2		17. INFORMANT Martha Reixach-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Plum Effusion + Cardio Vascular Collapse 11x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma - Prostate. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Sept 21 , 19 57 , to Dec 1 , 19 57 , that I last saw the deceased alive on 12-1 , 19 57 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5000 Kensington Rd Md DATE SIGNED 12-1-57							
ACTUAL SIGNATURE Wm. F. Luckett		M.D. 5000 Kensington Rd Md					
PHYSICIAN'S NAME (Type) Wm. F. Luckett							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur.-Tran.	22b. DATE THEREOF 12/2/57	22c. NAME OF CEMETERY OR CREMATORY St. John Cem.	22d. LOCATION (City, town, or county) (State) Orleans Parish-La.				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.			24a. REC'D BY REGISTRAR DATE 12-2-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13401
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admitt on) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10,705 Lockridge Road</u>		e. STREET ADDRESS <u>10,705 Lockridge Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMILIE (nmi) WAGEN</u>		4. DATE OF DEATH Month Day Year <u>December 30 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/80</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Switzerland</u>	
13. FATHER'S NAME <u>Jacob Hulftegger</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Leeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Walter W. Albersheim, Silver Spring, Md.</u>		Address <u>10,705 Lockridge Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized encephalopathy</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis & Hypertension</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>One month</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>December 31, 1957</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Dec. 31, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George's Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner G. Humphrey</u>		24a. REC'D BY REGISTRAR <u>MAN</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Vatter</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1917

13408

CERTIFICATE OF DEATH

13402

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md. (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewistown (Cumberland)</u>			
c. LENGTH OF STAY IN TB <u>5 days</u>				d. STREET ADDRESS <u>439 Walnut Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NMMC, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Thompson</u> Last <u>WALKER</u>				4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 February 1902</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Marines</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James WALKER</u>				14. MOTHER'S MAIDEN NAME <u>Bessie BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>(Brother) Robert Burns Walker</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infarction, myocardium</u> # <u>4701</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 December, 19 57</u> to <u>31 December, 19 57</u> , that I last saw the deceased alive on <u>31 December 19 57</u> , and that death occurred at <u>11:50A M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>C. U. Shilling</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>1-2-58</u>							
ACTUAL SIGNATURE <u>C. U. Shilling</u>							
PHYSICIAN'S NAME (Type) <u>C. U. Shilling LT MC USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Private Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Ruff</u> ADDRESS <u>Right Funeral Home, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 31 Dec 57</u> 24b. REGISTRAR'S SIGNATURE <u>Mary E. Cansell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7 2 1970

10-11-70

13409 CERTIFICATE OF DEATH

Reg. Dist. No. 13403

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		e. STREET ADDRESS 9909 Thornwood Road	
3. NAME OF DECEASED (Type or print) CLARE E. WARENDORFF		4. DATE OF DEATH Dec. 2, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1878
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 3 Days 18	IF UNDER 24 HRS Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist-Housewife		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Karge		14. MOTHER'S MAIDEN NAME Elizabeth Mertens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Walter P Warendorff same as 2d		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Nervous System DUE TO Arteriosclerosis (hypertension) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (hypertension) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1955 19__ to 12/2/57 19__, that I last saw the deceased alive on 12/2/57 19__, and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10443 Fenwick St Kensington DATE SIGNED			
ACTUAL SIGNATURE Samuel Allen		M. D. 10443 Fenwick St Kensington	
PHYSICIAN'S NAME (Type) SAMUEL ALLEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12/6/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Bessie M. Thompson	
ADDRESS Bethesda, Maryland		DATE 12-3-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

PLATE

13410 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Columbia ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
c. LENGTH OF STAY IN lb 19 days				d STREET ADDRESS 3226 Highwood Drive, S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillian Middle Carlene Last Warfield				4. DATE OF DEATH Month December Day 31 Year 19 57			
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH April 17, 1902	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 31 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing Profession	
11 BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles E. Warfield			
14. MOTHER'S MAIDEN NAME Anna Farmer				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16 SOCIAL SECURITY NO Unascertainable				17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism DUE TO Thrombophlebitis, left iliac and femoral veins Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) 464x (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Glioblastoma Multiforme							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 12, 19 57 , to December 31, 19 57 , that I last saw the deceased alive on December 31, 19 57 , and that death occurred at 8:20a M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE PETER T. ROWLEY M.D.				The Clinical Center 12/31/57			
PHYSICIAN'S NAME (Type) PETER T. ROWLEY, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec. 3, 1958		Cedar Hill		Smithland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Jones				ADDRESS Wash. D.C.		24a REC'D BY REGISTRAR 1958	
24b REGISTRAR'S SIGNATURE Wm. H. Jones				DATE 1958			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

AN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13411

CERTIFICATE OF DEATH

13405
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				d. STREET ADDRESS 4504 Harlen Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WALTER D. WARREN, Sr.				4. DATE OF DEATH Month Day Year Dec. 25 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1869		9. AGE (In years last birthday) yrs. Months Days Hours Min. 88 4 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Civil Engineer		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Warren				14. MOTHER'S MAIDEN NAME Rebecca Gates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Walter D. Warren, Jr.—Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes 10 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 56 , to Dec , 19 57 , that I last saw the deceased alive on 23 Dec , 19 57 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert Martyn Jr.		M.D. 5029		ADDRESS (Street, city or town, state) Bethesda Ave.		DATE SIGNED 25 Dec 57	
PHYSICIAN'S NAME (Type) HERBERT MARTYN JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Trans		22b. DATE THEREOF 12/28/57		22c. NAME OF CEMETERY OR CREMATORY Newton		22d. LOCATION (City, town, or county) (State) Newton, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-27-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU OF

DEC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13412 CERTIFICATE OF DEATH

Reg. Dist. No.

134068
298

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lilah Middle Washington Last Washington		4. DATE OF DEATH Month Dec. Day 4 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 4 Days 1 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Fairfax		14. MOTHER'S MAIDEN NAME Maria Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Washington Germantown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 day 3 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Germantown, Md.		(County) (State)	
21. I certify that I attended the deceased from Jan. 1955 to Dec. 4, 1957 , that I last saw the deceased alive on Dec. 4, 1957 , and that death occurred at 10:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Vernon E. Martens M.D.		ADDRESS (Street, city or town, state) Germantown, Md. DATE SIGNED 12-5-57	
PHYSICIAN'S NAME (Type) Vernon E Martens		m d	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/57	22c. NAME OF CEMETERY OR CREMATORY Brooke Grove	22d. LOCATION (City, town, or county) (State) Laytonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DEC 11 1957		24b. REGISTRAR'S SIGNATURE Charles G. Cook	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

U.S. DEPT. OF JUSTICE

13407

13413

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Marylander		d. STREET ADDRESS Waters Road	
3. NAME OF DECEASED (Type or print) MARY ELEANOR CISELL WATERS		4. DATE OF DEATH Dec. 19, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1887
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR: Months 2 Days 15 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Humphrey Cissell		14. MOTHER'S MAIDEN NAME Julia Griffith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Ella V. Gochenour-Germantown, Md.		Address Waters Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Culmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Coronary Disease		INTERVAL BETWEEN ONSET AND DEATH 2 hours 1 day 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 50 , to Dec 19 , 19 57 , that I last saw the deceased alive on Dec 19 , 19 57 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE V. E. Mathias		ADDRESS (Street, city or town, state) Bethesda, Md.	
PHYSICIAN'S NAME (Type) V. E. Mathias		DATE SIGNED	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 12/21/57	22c. NAME OF CEMETERY OR CREMATORY Neelsville Ch. Cem.	22d. LOCATION (City, town, or county) (State) Neelsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DEL 23 1957	
		24b. REGISTRAR'S SIGNATURE Amanda Cooke	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

LC 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13414 CERTIFICATE OF DEATH

13409

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE District of Columbia b. COUNTY Washington ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 80 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3239 P Street, N.W.	
3. NAME OF DECEASED (Type or print) First Leslie Middle Allyne Last Wells		4. DATE OF DEATH Month December Day 20 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1901
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Photographing	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Delbert M. Wells		14. MOTHER'S MAIDEN NAME Annette Boswell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 181-10-1828	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC RENAL CELL CARCINOMA DUE TO (c) CARCINOMA OF RIGHT KIDNEY			
INTERVAL BETWEEN ONSET AND DEATH ONE HOUR 2 1/2 YEARS 2 1/2 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUODENAL ULCER			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 1, 1957 , to December 20, 1957 , that I last saw the deceased alive on December 20, 1957 , and that death occurred at 11:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-20-57 ACTUAL SIGNATURE Richard K. Shaw M.D. PHYSICIAN'S NAME (Type) Richard K. Shaw, M.D. The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's son		24a. REC'D BY REGISTRAR DATE DEC 20 1957	24b. REGISTRAR'S SIGNATURE Beattie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 27 1957

BUREAU 7

CERTIFICATE OF DEATH

13410

Reg. Dist. No. 218

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		c. LENGTH OF STAY IN 1b 20 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Amanda Ward Whelan		4. DATE OF DEATH Month Dec. Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1888
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR: Months 17 Days 19 Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas G. Ward		14. MOTHER'S MAIDEN NAME Martha V. Whalen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, na or unknown) #### (If yes, na or unknown) ####		16. SOCIAL SECURITY NO. None	
17. INFORMANT George T. Whalen,		Address Derwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertensive Cardiorenal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Sclerosis with Senile Dementia.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 4, 1957 to Dec. 17, 1957 , that I last saw the deceased alive on Dec. 17, 1957 , and that death occurred at 12:07 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell M.D.		ADDRESS (Street, city or town, state) Nrobeck Rt. 1, Silver Spring, Md.	
DATE SIGNED 12/18/57			
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 20 57	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Abraham L. Cooke	
DATE Dec 21-57			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 2 1957

BUREAU V. 9

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quince Orchard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quince Orchard</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gaithersburg, R. F. D.</u>		e. STREET ADDRESS <u>Gaithersburg, R. F. D.</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WHITE</u> Last <u>WHITE</u>		4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John White</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Bacon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mrs Sarah White, Gaithersburg, Md.</u>	
17. INFORMANT <u>Mrs Sarah White, Gaithersburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4-4-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>dissecting aortic aneurysm</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>Dec 27, 1957</u> that I last saw the deceased alive on <u>Dec 27, 1957</u> and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. R. Fothergill</u> M.D.		ADDRESS (Street, city or town, state) <u>26 N. Summit Ave., Gaithersburg, Md.</u>	
DATE SIGNED <u>12/27/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert L. Szwed</u>		ADDRESS <u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View</u>		22d. LOCATION (City, town, or county) (State) <u>Quince Orchard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Szwed</u>		24a. REC'D BY REGISTRAR <u>Jan 2 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Alvin G. Cook</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1900

RECEIVED
JAN 2 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13287

CERTIFICATE OF DEATH

Reg. Dist. No.

13412

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>7 days</u>				d. STREET ADDRESS <u>2405 Dennis Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Augustine</u> Last <u>Wilkinson</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/17/04</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Claims Adjuster</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Wilkinson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Minnock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Wife</u> Address <u>same as above.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>Recurrent myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO <u>the two above</u> (c) <u>5 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u> </u> , to <u>7/11/57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12/4/57</u> , 19 <u> </u> , and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard J. Walsh</u> M.D.				ADDRESS (Street, city or town, state) <u>900-17th St. N. W.</u> DATE SIGNED <u>12/11/57</u>			
PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Thompson</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

REC 11 1947

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 2 & 4, Film 6-2-1/3/50-8-5

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York MARYLAND b. COUNTY KINGS PARK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON Kings Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4120 Wexford Court		d. STREET ADDRESS Home T. State Hospital	
3. NAME OF DECEASED (Type or print) LEON R. WILLIAMS		4. DATE OF DEATH Dec. 9, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 29 Oct. 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas R. Williams		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 128-05-3101	
17. INFORMANT Maj (Ar.) Williams		Address 4120 Wexford Ct.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident, thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Arteriosclerosis & insufficiency DUE TO (c) unknown			INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease with myocardial infarction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 23 October , 1957, to 9 December , 1957, that I last saw the deceased alive on 8 December , 1957, and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard F. Clowdus M.D.		ADDRESS (Street, city or town, state) 1100 th USAF Hospital	
PHYSICIAN'S NAME (Type) BERNARD F. CLOWDUS, M.D.		Bolling AFB, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12/12/57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l	22d. LOCATION (City, town, or county) (State) Ft. Myer Va.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 3072 14th St NW Wash. DC	24a. REC'D BY REGISTRAR DEC 11 1957
		24b. REGISTRAR'S SIGNATURE Frances Pitter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. 100

100

13414

13418

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>MD.</u> COUNTY <u>?</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Kensington</u>		LENGTH OF STAY (In this place)		TOWN <u>WESTMORELAND HILLS</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Keningston Gardens Sanitarium</u>				STREET ADDRESS (If rural give location) <u>5210 ARBINGTON ROAD</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>HARRY L. WILLIAMSON</u>				<u>Dec. 19, 1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>Nov. 19, 1884</u>	<u>73</u> yrs.	Months <u>1</u>	Days <u>0</u>	Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>General Insurance</u>					<u>Philadelphia, Pa.</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Williamson</u>				<u>Louise Ebelhere</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
					<u>Mrs. Lindell Leathers</u> <u>5210 Arington Rd. Washington D.C.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9/11/57</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/11</u>, 19<u>57</u>, to <u>12/19</u>, 19<u>57</u>, that I last saw the deceased alive on <u>11/30</u>, 19<u>57</u>, and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Aris Carpanis</u> M.D.				ADDRESS (Street, city, town, state) <u>2801 Wisconsin Ave NW DC</u>		DATE SIGNED <u>12/20/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Dec. 20, 1957</u>		<u>Warm Springs Cemetery</u>		<u>Warm Springs, Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>DATE 12-21-57</u>		<u>Bessie M. Thompson</u>		<u>Ives Funeral Home C. M. Ives</u> <u>2847 Wilson Blvd., Arlington, Va.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. A.

DEC 27 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9913 Woodburn Rd. Silver Spring Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>Takoma Park</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Robert Karl Wilson</u>		4. DATE OF DEATH <u>December 4</u> 19 <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9-1905</u>
9. AGE (In years last birthday) <u>52</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Display</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hecht Company</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>Robert P Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Melissa Gale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Cora S. Wilson, 9913 Woodburn Rd. Silver Spring, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Thrombosis</u> 3 wks DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio Sclerotic Cardiovascular dis.</u> 10 yrs DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, Oct. 1957</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 16</u> , 19 <u>57</u> , to <u>Dec 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>57</u> , and that death occurred at <u>4:57</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Orleans</u> M.D.		ADDRESS (Street, city or town, state) <u>9500 Colesville Rd Silver Spring Md</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>H. B. ORLEANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City town or county) (State) <u>Montgomery County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 6 1957</u> 24b. REGISTRAR'S SIGNATURE <u>J. Nelson, Daddy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with page 1. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

U. S. DEPT. OF JUSTICE

RECEIVED
JAN 10 1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13419

CERTIFICATE OF DEATH

13417216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Virginia b. COUNTY Dinwiddie			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 92 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle LEWIS Last Wood				4. DATE OF DEATH Month December Day 25 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 7, 1907	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Education			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ashton Lewis				14. MOTHER'S MAIDEN NAME Mattie Alley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 225-42-8272		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency INTERVAL BETWEEN ONSET AND DEATH 2 wks.							
DUE TO Bilateral hydrothorax 2 wks.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leiomysarcoma, metastatic 2 yrs.							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from September 24, 1957 , to December 25, 1957 , that I last saw the deceased alive on December 25, 1957 , and that death occurred at 1:15 A M, from the causes and on the date stated above.							
SIGNATURE Kurt W. Kohn, M.D.				ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 12/25/57							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION Buried				22b. DATE THEREOF Dec 27, 1957		22c. NAME OF CEMETERY OR CREMATORY HOME CHURCH CEMETERY	
22d. LOCATION (City, town, or county) FORD, DINWIDDIE COUNTY, VA.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James H. H. H.				ADDRESS 254 Carroll St NW		24. REC'D BY REGISTRAR DEC 27 1957	
25. REGISTRAR'S SIGNATURE Bessie Thompson							

RECEIVED

DEC 27 1964

BUREAU H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13289 CERTIFICATE OF DEATH

13418
Reg. Dist. No. 223

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>7 days 14 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
f. STREET ADDRESS <u>1005 Houston Ave</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Geraldine</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-26-83</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Henry Holser</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Steward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>0</u>		17. INFORMANT <u>Washington Sanitarium and Hospital Records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonitis, congestive</u> DUE TO <u>non-filling gallbladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>Cholecystostomy for cholecystitis and</u> DUE TO <u>Garcinoma of body of pancreas</u> (c) <u>metastatic carcinoma of liver, testes</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>11-30-57</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <u>Rigid bundle branch block with possible anterolateral infarction</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>11-24</u> , 19 <u>57</u> , to <u>12-8</u> , 19 <u>57</u> that I last saw the deceased alive on <u>11-30 P.M. 12-7 1957</u> , and that death occurred at <u>7:07 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Read N. Calvert</u> M.D. <u>7894 Ga. Ave., Silver Spring, Md.</u>				DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>READ N. CALVERT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH. CEMETERY</u>		22d. LOCATION (City, town, or county) <u>Riggs Rd., Hyattsville, Prince Georges Md.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u>2514 Carroll St. NW.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>12/11/57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. 3

DEC 17 1937

RECEIVED

13420 CERTIFICATE OF DEATH

Reg. Dist. No. 13419
216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		d. STREET ADDRESS 4104 East West Highway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First E Middle Nisbet Last Wright		4. DATE OF DEATH Month December Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1873
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Henry Wright		14. MOTHER'S MAIDEN NAME Mary Frances Nisbet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Florence H. Wright, 4104 East West Highway, Chevy Chase, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma right lung with metastasis to left humerus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 260X (b) DUE TO (c) 163X		INTERVAL BETWEEN ONSET AND DEATH 2 yrs + 3 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 2) Pathologic fracture left humerus No 014 1957		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 29, 1957 , to Dec , 1957, that I last saw the deceased alive on Dec , 1957, and that death occurred at 6:50 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St. N.W. Wash 15 D.C. DATE SIGNED			
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St. N.W. Wash 15 D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF Dec. 13, 1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland Rd., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home 5103 Wisconsin		24a. REC'D BY REGISTRAR DATE 12-18-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Bessie M. Hornsby	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

RECEIVED
DEC 23 1957
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13420

13421 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>4123 Woodbine St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>T</u> Last <u>Youngs</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Biologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Young</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Dalzell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Young (son)</u>		Address <u>4123 Woodbine St. Chevy Chase</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Stomach with Hepatic Metastases</u> DUE TO (c) <u>Months</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>57</u> , to <u>Dec 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>57</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md.</u> DATE SIGNED <u>12/9/57</u>			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>12/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>12-11-57</u>	24b. REGISTRAR'S SIGNATURE <u>Benjamin M. Thompson</u>

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 12 1957

RECEIVED